October 2025 Kansas Survey Findings
Normal Font-Health Survey
Italics= Complaint Survey
Findings in Red=G+ Scope & Severity
Findings in Green from State Regulations
SS=Scope & Severity; LN=Licensed Nurse
TX=treatment; Dx=Diagnosis; Fx=Fracture
CP=Care Plan; CP in pharmacy regulations=Consultant Pharmacist
PU=Pressure Ulcer; ID=identify; Hx=History; MDD=Major Depressive Disorder

June 2025
July 2025
August 2025
September 2025

F550 Resident Rights/Exercise of Rights

SE: SS=D: Failed to protect the dignity of 3 residents when resident was transported from room to shower room via a shower chair only covered with a white sheet with buttocks exposed; additionally, staff entered the rooms of 3 residents w/o knocking first & did not identify themselves or await acknowledgment from resident placing residents at risk for negative psychosocial effects r/t impaired dignity

- Observed CAN knocked on resident's room door 1x then entered w/o acknowledgement while resident being interviewed & resident stated staff frequently entered room w/o knocking or waiting for permission
- Observed resident's room door closed & CNA opened door & entered w/o knocking or introducing self
- Observed LN assisting resident with BR cares & while resident receiving care, LN opened resident's door w/o knocking & looked into room, looking for another staff member & then CNA pushed resident's door open w/o knocking & walked into room with food tray
- Observed staff wheeled resident from room to shower room in shower chair past DR & resident with sheet over lap & bare legs & bare buttocks exposed

NE: SS=D: Failed to show respect & dignity to 1 resident when staff left window-blinds open during cares placing resident at risk for impaired dignity & embarrassment

- Observed Adm Nurse & CNA entered room to perform peri-care & removed cover from resident & turned resident to window & window in room looked onto front parking lot with blanks raised 12 inches

NE: SS=D: Failed to provide a dignified care environment for 2 residents placing residents at risk for impaired dignity and unmet care needs

- Observed resident wheeled to DR with w/c lacking foot pedals & feet sliding on floor as pushed then staff stared serving trays 2 at a time at 7:55am the at 8am resident informed staff was hungry; at 8:10am 2 other residents at table had food; at 18:15am staff placed plate of food in empty seat next to resident; at 8:20am majority of room had already served meals except this resident; at 8:30am resident received meal & began eating & majority of room had completed meals before resident received plate; observed meals served on Styrofoam plates r/t dishwasher "broken" since last week
- Incident Report documented incident occurred between dietary staff & 1 resident indicating staff got into verbal aggressive argument with resident in dining area during meal service; report indicated resident asked staff for mild & staff informed resident could not have milk & staff became verbally aggressive with resident when asked why could not have milk; staff removed from facility & immediately suspended; resident stated felt threatened that staff would assault resident over carton of milk

NW: SS=E: Failed to promote care in manner to maintain & enhance dignity & respect when staff used Styrofoam plates & bowls instead of regular dinnerware for meal service placing residents of facility at risk for impaired dignity

- Observed meal service that staff provided Styrofoam plates for mail plate & desserts; observed another meal that staff provided Styrofoam plates for meal & cereal; staff stated used Styrofoam plates & bowls because kitchen short-staffed & did not have enough help to clean dishes

NW: SS=D: Failed to treat 1 resident with dignity at the dining table when CNA stated, "Here is your bib," & placed a clothing protector on resident

- Observed resident at DR table & CNA brought clothing protector to resident's table & stated, "Here is your bib" & placed clothing protector on resident

F552 Right to be Informed/Make Treatment Decisions

SE: SS=E: Failed to ensure informed consent including purpose, risks vs benefits, & expected therapeutic benefits for use of antipsychotic, anxiolytic & other psychotropic medications 5 residents placing residents at risk for adverse side effects of medications & uninformed decisions

- POS for Sertraline, Trazodone, Buspirone, Seroquel; EMR lacked documentation of informed consent for resident's psychotropic & antipsychotic meds
- POS for Seroquel, Trazodone, Clonazepam; EMR lacked documentation of informed consent for psychotropic & antipsychotic meds
- POS for Buspirone; EMR lacked documentation of informed consent for psychotropic meds

- POS for Hydroxyzine, Duloxetine, Buspirone; EMR lacked documentation of informed consent for psychotropic meds
- POS for buspirone, Seroquel, Clonazepam; EMR lacked documentation of informed consent for psychotropic & antipsychotic meds

SE: SS=D: Failed to inform 3 residents/representatives regarding risks r/t psychotropic meds with potential to lead to uninformed decisions regarding treatment

- Adm Nurse stated that psychotropic informed consents were to be completed prior to starting the psychotropic medication, increasing dosage, or increasing the schedule. Adm Nurse also stated that nurses were allowed to perform informed consents. Adm Nurse verified the start date for Seroquel was 04/01/25, & Zyprexa was 03/28/25, and consent was not done until 09/02/25
- POS for Clonazepam, Desvenlafaxine, Lamotrigine, Latuda & EMR lacked documentation of informed consent for resident's psychotropic & antipsychotic meds
- POS for Lorazepam, Mirtazapine; EMR lacked documentation of informed consent for resident's psychotropic meds

SE: SS=D: Failed to ensure informed consent including purpose, risks vs benefits & expected therapeutic benefits for use of antipsychotic, anxiolytic & other psychotropic meds for 1 resident

- POS for Latuda, Pristiq, Remeron, Xanax; EMR lacked documentation of informed consent for psychotropic meds

SW: SS=E: Failed to inform 5 residents/representatives r/t risks r/t psychotropic medications

- POS for Escitalopram (antidepressant) & record lacked evidence of informed consent r/t medication
- POS for Divalproex for MDD & Seroquel for psychotic d/o & record lacked evidence of informed consent r/t medications
- POS for Alprazolam for anxiety & Zoloft & record lacked evidence of informed consent r/t medications
- POS for Risperidone for dementia & record lacked evidence of informed consent r/t medication
- POS for Seroquel for borderline personality d/o, Divalproex for borderline personality d/o, Olanzapine for borderline personality d/o; Escitalopram & Clonazepam for anxiety & record lacked evidence of informed consent r/t medications

NE: SS=E: Failed to inform 5 residents/representative regarding the risks r/t psychotropic meds with potential to lead to uninformed decisions r/t tx

EMR with psychotropic consent signed & dated, listed psychotropic med types with side effects but lacked names of individual meds & prescribed dosages; POS for Buspar, Cymbalta; Adm stated that psychotropic consents had been completed as required by having the type of medication listed on the consent. Adm further stated that the resident had been verbally educated about individual medication, the medication dosage, & why they were prescribed it, but that was not documented for multiple residents

F553 Right to Participate in Planning Care

SE: SS=D: Failed to include 1 resident/representative in development & planning of resident's care plan placing resident at risk of impaired care & decreased autonomy

- Resident with dementia; EMR revealed admission date of 11/02/22 with CP signature pages of attendance for 07/09/24 & 12/18/24 that showed resident had attended & participated in CP; EMR lacked evidence that resident was invited &/or included in any further CP meetings; resident stated had not been informed or invited to CP meetings

F558 Reasonable Accommodations Needs/Preferences

SW: SS=D: Failed to provide footboard or footrests for 2 residents

- Observed resident in w/c with no footrests & feet dangling approx. 2 inches off ground; observed CNA propelled resident down hallway in w/c & feet dangled off ground; observed resident on multiple occasions in w/c with feet dangling & resident unable to place feet on ground; staff reported resident did not have foot pedals for w/c but used to but removed r/t pain of bending knees to apply feet to pedals
- Observed resident in w/c w/o foot pedals & feet dangling approx. 2 inches off ground; resident unable to place feet on ground; staff reported resident had never had pedals on w/c

F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive

SW: SS=D: Failed to ensure 2 resident's advanced directives were accurately reflected when 1 resident had a DNR form completed but had an order for a full code; additionally, 1 resident's DNR lacked resident/responsible party & witness signature; 1 resident declined DNR in 2016, and the facility had a DNR order

- POS for Full code; CP instructed staff to perform CPR but EMR revealed DNR signed by resident & physician
- POS for DNR & resident's DNR documented physician signature only but lacked witness, representative &/or resident signature
- POS for DNR & CP instructed staff that resident had signed DNR in record but EMR document indicated resident did not agree to DNR

F580 Notify of Changes (Injury/Decline/Room, etc.)

SW: SS=D: Failed to notify representative of changes in weight for 1 resident

- Quarterly MDS of 9-8-25 indicated resident with weight of 139 #s, with mechanically altered diet & resident with significant weight loss; CP & POS documented resident with pureed diet with honey-thick liquids; "Mini Nutritional Eval" dated 9-18-25 documented

resident with malnourishment with weight of 140.2 #s; record documented weight of 160 #s on 3-21-25 & 140.6 #s on 9-19-25; record lacked documentation that resident's representative notified of weight loss;

F583 Personal Privacy/Confidentiality of Records

SW: SS=D: Failed to protect privacy of 1 resident when CNA took video of resident w/o resident's consent

- *Resident with dementia with BIMs of 99; investigation report indicated night shift CNA showed video r/t resident to another CNA during shift change; video showed fully clothed resident in bed with BM on resident & wall; other CNA reported incident to Adm & Adm suspended CNA until investigation completed; Adm notified resident's representative, law enforcement & SA; video review unable to tell identify of resident in video*

NE: SS=E: Failed to keep 5 residents protected health information (PHI) private on med cart parked in main DR

- Observed med cart parked in hallway with laptop open on cart & no LN or CMA around cart & computer screen unlocked & open with resident's PHI on screen, visible to all who passed by med cart; observed 4 med carts parked in common room with laptop computer opened on carts & LN & CMA walked away form carts & in DR; LN & CMA left computer screen unlocked & open & PHI for 4 residents were visible on screen to all who passed by med carts

F584 Safe/Clean/Comfortable/Homelike Environment

SE: SS=F: Failed to ensure safe, clean home-like environment in resident's rooms & facility common areas

- Observed: resident room with trim-molding around base peeled off & paint peeling off, exposing sheetrock; inside of room door with exposed wood & splintered areas; observed BR door with pain missing & exposed wood & door frame to BR with peeling paint, exposing bare metal; observed corner of wall with trim missing, exposing hole; ceiling with bubbled, missing & peeling paint; blinds bent; chipped paint & door broken with exposed splintered wood; walls with separated, cracked & peeling areas & blinds dusty with broken & bent slats; AC vent & fire suppression sprinkler head with unknown organic substance; fluorescent lights partially hanging down; AC vents with fuzzy substance; lobby area with fuzzy substance

F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to ensure 1 resident's w/c foot pedals were utilized while being pushed; additionally failed to ensure 1 resident had a way to communicate needs due to call lights being left out of reach placing residents at risk for preventable accidents & injuries

- Observed staff pushing resident in w/c w/o foot pedals
- Observed resident with call light laying between bed & roommate's bed on floor & not within reach

NE: SS=E: Failed to utilize foot pedals during wheelchair transports for 4 residents placing residents at risk for preventable accidents

- Observed resident wheeled from room to DR in w/c w/o foot pedals & feet slid on ground as being pushed for multiple residents

NW: SS=D: Failed to provide accommodation of needs for 1 sampled resident who had a call light on wall that was unreachable from bed placing at risk for preventable accidents & injuries

- Observed on multiple occasions resident in room with call light hanging on wall & light unreachable by resident

NW: SS=D: Failed to accommodate 1 resident's needs when failed to ensure resident's walker could safely fit into BR after resident's admission to facility placing resident at risk for falls as resident would leave walker outside BR door & furniture walk in BR use toilet & wash hands

- Resident with fall risk; EMR lacked notes r/t accommodation of needs or pain; resident stated had been in facility for almost 2 weeks & very disappointed in care had received so far & did not feel safe going to BR because walker would not fit into BR & had to leave walked by door & use sink & door frame to get into BR to get to toilet; observed resident used walker to walk to BR then tried to get walker into BR but walker would not fit; observed resident moved into different room p hall & walker did not fit into BR & resident stated BR even worse than 1st BR; resident stated moved so old room floor could be "redone"; then resident moved to another different room on different hall & resident stated new BR much bigger & walker fit into it & felt safe going to BR

F576 Right to Forms of Communication w/Privacy

SE: SS=C: Failed to provide residents of facility with reasonable access to receive mail

- *Resident stated "young lady" who delivered mail does not work on weekends so did not think residents received mail on Sunday; resident stated wished got mail on Saturday but staff who deliver mail don't work on weekends; LN stated did not observed any mail being delivered on weekends*

F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive

SW: SS=D: Failed to ensure 2 residents' advanced directives were thoroughly completed when 1 resident had a DNR order but not signed DNR form; additionally, 1 resident's DNR lacked a witness signature

- POS for DNR signed by resident & physician but lacked witness signature
- Resident's EMR lacked signed DNR form but had POS for DNR

F582 Medicaid/Medicare Coverage/Liability Notice

NW: SS=D: Failed to provide 3 residents/representatives, the completed Skilled Nursing Facility Advanced Beneficiary Notices (ABN) form 10055 placing residents at risk of uninformed decisions about skilled services

- 3 resident's Part A Medicare discharge papers revealed facility had not provided residents with Medicare ABN form 10055 disclosing cost of continuing skilled services; Adm verified facility lacked documentation that ABN form 10055 provided to discharged residents

F583 Personal Privacy/Confidentiality of Records

NE: SS=D: Failed to secure protected health information (PHI) for 1 resident placing resident at risk for decreased psychosocial well-being due to a lack of privacy

- Observed unattended nursing cart with resident's PHI displayed on cart; LN exited room & locked computer screen

F584 Safe/Clean/Comfortable/Homelike Environment

SE: SS=E; Failed to ensure a safe, clean home-like environment in all areas of facility, including dining area placing residents at risk for tripping hazards & decreased comfort

- Observed fall mat & room floor with sticky food particles & debris; floor in DR with 44 missing tiles no hazard sign or barrier blocking trip hazard on multiple occasions; door on resident room with bubbling on surface where Veneer separating; door frames bubbled, chipped & missing paint

SE: SS=E: Failed to ensure a safe, clean home-like environment in residents' rooms & common areas placing residents at risk for tripping hazards, electrical accidents, respiratory hazards & decreased comfort

- Observed multiple dark spots on floor at HOB & molding missing from base of wall next to BR door with exposed & broken drywall; damaged ceiling areas with exposed sheet rock & floor dirty & stained; resident room with wall with exposed dry-wall & paint missing & floor dirty & sticky; hallway & resident rooms with chipped & cracked floor tiles & some tiles bubbled & with numerous areas risen, exposing concrete floor underneath; observed crack from top of door frame up & across ceiling & down wall to top of other resident room; broken wall tile; 220-volt plug outlets in DR & hallway 6 inches off ground & all were live & originally thought to be not hooked up

SE: SS=E: Failed to ensure a safe, clean home-like environment in residents' rooms placing residents at risk for safety & decreased comfort

- Observed ceiling with paint peeling & large water stain around peeled area; resident room wall scuffed with paint rubbed off & end of fluorescent ceiling light with cover bent out with exposed wires & wall with chipped paint & BR door with areas scraped on bottom & multiple holes in door; shower room with missing tiles around drain, missing caulking around shower floor, missing & hanging trim around shower ceiling & gap on 1 side of light switch cover to shower light; multiple ceiling vents dirty & rusty; ceiling in therapy dept with flaked areas exposing sheetrock

F600 Free from Abuse & Neglect

NE: SS=D (Past Noncompliance): Failed to prevent an episode of staff-to-resident physical abuse of a cognitively Impaired Resident placing resident at ongoing risk for preventable abuse & mistreatment

- *"Facility Incident Report #6463" completed on 07/07/25 indicated resident got into a physical altercation with LN on 07/07/25. The report indicated CNA witnessed physical altercation between resident & LN. The report indicated resident was agitated & stood up from w/c. The report indicated resident then pushed LN away from resident. The reporter noted that LN pushed resident back & stated, "We don't push here". The report indicated LN was immediately suspended & terminated from facility. The report noted resident was assessed with no injuries found. The report indicated resident's medical provider & resident representative were immediately notified of the incident. The report noted that law enforcement & the state agency were notified*
    - *Plan of Removal:*
        - *All staff were educated on Abuse, Neglect, & Exploitation on 07/09/25.*
        - *The facility identified & screened all residents under the care of LN. No other residents reported abuse.*
        - *The facility will track staff education & in-service training in the Quality Assurance and Performance Improvement program for abuse, dementia care, resident rights, and communication*

NE: SS=J (Plan of Removal to G): Failed to ensure residents remained free from sexual abuse when cognitively impaired resident, a resident with hx of inappropriate touching, touched other resident's genital area against other resident's wishes

- . On 07/18/25, resident touched a lady "in a sexual way," and the facility sent resident to hospital for inappropriate behavior; resident returned to facility on 07/25/25, but facility did not implement interventions to address resident's inappropriate touching; on 08/28/25, resident exhibited sexual behaviors towards staff, but facility did not address these behaviors with new interventions; on 08/29/25, resident touched cognitively impaired other resident, a resident unable to consent, in other resident's genital area; other resident screamed at resident to stop touching other resident; staff separated resident & other resident & placed resident under 1:1 staff supervision until resident transferred to an all-male unit in another facility; facility's failure to identify & implement interventions in response to resident's inappropriate touching & behaviors to prevent sexual abuse placed other resident in immediate jeopardy

- Plan of Removal:
    - The facility screened all residents on secured unit on 09/01/25.
    - Facility assessed both resident & other resident for psychosocial trauma from incident.
    - Facility will monitor & provide ongoing education through QAPI team.
    - All staff were educated on ANE on 08/30/25.
    - Resident was immediately placed under 1:1 staff supervision on 08/29/25 until transfer from facility on 09/04/25.

F602 Free from Misappropriation/Exploitation

NE: SS=E (Past Noncompliance): Failed to ensure 4 residents remained free from misappropriation of medications with risk for missed medications & further misappropriation of meds for affected residents

- *Facility's "Investigation" dated 06/03/25, documented on 05/26/25 around 06:35 PM, 2 LNs completed narcotic count at change of shift & noted a small piece of tape on back of bubble pack. LN notified Adm Nurse & other Administrative Nurse, who both arrived at facility to investigate. Upon investigation, facility noted a narcotic medication bubble pack had been tampered with, which involved a slit in the foil & small piece of tape placed on back of the bubble pack. 1 resident's oxycodone was tampered with, & resident missed eight tablets of oxycodone, which had been replaced with fludrocortisone tablets. 1 resident's oxycodone was tampered with, and resident missed 21 tablets of oxycodone, which had been replaced with fludrocortisone tablets. 1 resident was missing 16 tablets of fludrocortisone. 1 resident was missing 8 tablets of fludrocortisone. The facility followed narcotic count policy, but minute change in medication card was difficult to detect. The facility immediately started investigating, which included drug testing all staff who passed medications or were licensed nurses. The facility notified the police & immediately replaced meds. The facility reviewed 24-hour video surveillance & noted suspicious footage of 1 CMA. On 05/28/25, CMA arrived for work, & facility asked CMA to go to Adm's office to meet with Administrative Staff & Administrative Nurse. Facility showed CMA video surveillance, & CMA offered no explanation of actions on camera. Facility asked CMA what she was doing in video, & CMA responded that did not know. Facility suspended CMA pending investigation & later terminated CMA that day for refusing to provide information r/t investigation*
    - *Plan of Removal: The facility put the following corrective actions into place prior to the onsite visit with compliance date of 07/02/25:*
        - *The facility drug tested all nurses & CMAs prior to their next shift from 05/26/25 to 05/30/25.*
        - *The facility reported the missing medications to police on 05/26/25.*
        - *The facility completed narcotic count policy education with all nurses and CMAs from 05/26/25 to 05/30/25.*
        - *The facility replaced & paid for the missing medications for 4 residents on 05/27/25.*
        - *The facility suspended then terminated CMA on 05/28/25.*
        - *The facility completed ANE training with all staff on 07/02/25.*

F605 Right to be Free from Chemical Restraints

SE: SS=D: Failed to ensure a14-day stop date or justification for continuation of a PRN psychotropic medication including a specified duration for 1 resident placing resident at risk of unnecessary psychotropic medication & related adverse effects

- POS for Clonazepam 0.5mg q 8 hrs PRN for sleeplessness/anxiety & order lacked stop date; EMR lacked specific duration with physician justification to continue PRN Clonazepam

SW: SS=E: Failed to ensure that 4 residents were free from antipsychotic medication use w/o appropriate indication for use, a GDR or ensure physician provided risk vs benefit for continued use of antipsychotic medications placing residents at risk of unnecessary med administration & related complications

- POS for Seroquel for unspecified dementia with behavioral disturbance; MRR from January 2024 thru July 2025 with no recommendations for appropriate CMS indication for use of antipsychotic; GDR recommended but declined by physician due to increased behaviors; Adm Nurse stated physician reviewed MRR but did not sign off & facility did not have physician do a risk/benefit rationale & assumed physician knew CMS's indication of use & rationale for continued use & documentation
- POS for Quetiapine for increased behaviors for dementia with behavioral disturbance; Physician progress note documented reduction not clinically indicated for: increased refusal of care, behavior issues, & combativeness despite alternative interventions; MRRs for 2025 lacked mention of appropriate indication of use for Quetiapine
- POS for Quetiapine with no indication included; physician progress note documented

SW: SS=D: Failed to ensure that 1 resident's PRN anti-anxiety medication had required 14-day stop date or specified duration with a physician's rationale to support the extended use

- Resident with dementia & depression; POS for Lorazepam cream PRN for dementia with agitation & order lacked stop date; MRR documented no stop date for PRN Ativan noted

NE: SS=D: Failed to ensure physician ordered laboratory tests to monitor antipsychotic medication for 1 resident were completed; also failed to ensure physician had documented a rationale with risk vs benefits for continued use of antipsychotic medication with no GDR for 1 resident

- POS for Haldol injection daily r/t schizophrenia with CBC & Haldol levels q 3 months; EMR lacked test results & facility unable to provide evidence of results for 4 scheduled tests
- POS for Buspar, Olanzapine, Risperdal, Trazodone, Xanax; facility unable to provide physician documentation that GDR clinically contraindicated

NW: SS=failed to ensure appropriate indication, or a documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of 1 resident's antipsychotic medication placing resident at risk for unintended effects related to psychotropic drug medications

- Resident with Alzheimer's disease & anxiety; CP recorded resident received antipsychotic for dx of irritability & anger/physical aggression; POS for Seroquel TID for irritability & anger; EMR lacked documented physician rationale including unsuccessful attempts for nonpharmacological symptom management & risk fs benefits statement for Seroquel use; Adm nurse stated facility had been working with physician to get appropriate dx's for residents on antipsychotic meds

NW: SS=D: Failed to ensure an appropriate indication, or a documented physician rationale, which included the unsuccessful attempts for nonpharmacological symptom management & risk vs benefits for continued use of 1 resident's antipsychotic medication

- POS for Seroquel TID for normal pressure hydrocephalus; EMR lacked documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management & risk vs benefits statement for Seroquel use

F606 Not Employ/Engage Staff w/Adverse Actions

NW: SS=D: Failed to provide background checks for 3 CNAs who had been employed with facility since 2023 and 2024

- Review of background checks revealed facility failed to complete background checks for 3 CNAs

F609 Reporting of Alleged Violations

NW: SS=D: Failed to report to state agency allegation of abuse & neglect when 1 resident slapped another resident placing residents at risk for ongoing abuse &/or mistreatment

- Resident with dementia & anxiety; CP documented resident with potential to be physically/verbally aggressive of hitting, kicking, biting & spitting on other residents, screaming out & using profanities; NN documented another resident wandered into resident's room, loud yelling heard & other resident walked out of room holding face & other resident stated resident hit other resident in face & other resident removed from resident's room; EMR lacked evidence investigation, including witness statements was reported to State & facility unable to provide investigation r/t event that was sent to State

F610 Investigate/Prevent/Correct Alleged Violation

SE: SS=D: Failed to provide protective measures for 1 resident following allegation of abuse placing resident at risk for abuse

- *EMR and information provided by facility revealed on 06/29/25 resident made accusation of sexual abuse by staff while toileting. Staff approached resident at approximately 11:15 in resident's room as resident was in a chair watching TV & yelling. When staff entered resident's room, resident yelled at staff to get out. The resident then heard by staff saying he was tired of staff waking resident up to play with his "butthole and ding-dong" and was going to get them for sexual assault. Staff assessed resident for physical & emotional safety at approximately 11:30 AM & resident stable with no signs of distress or harm; facility unable to provide evidence alleged perpetrator of abuse was removed from facility & denied access to residents during investigation of accusation*

NW: SS=D: Failed to ensure staff investigated potential allegations of abuse, including injuries of unknown origin, & report to administrator immediately to investigate allegation

- NN documented resident with dark purple discoloration to forearm with no reports of pain or discomfort & resident did not know how it occurred; EMR lacked any investigative notes r/t incident, including witness statements, root cause or investigation; staff verified facility did not investigate or gather witness statements

F627 Inappropriate Discharge

NE: SS=D: Failed to include required information on an emergency discharge notice for 1 resident & on a 30-day discharge notice for 1 resident with risk for miscommunication between facility & resident/family, a possible missed opportunity for healthcare services, & involuntary discharge for 2 residents

- *Resident with schizophrenia, TBI; CP documented resident with ability & hx of being physically aggressive r/t anger, poor impulse control & TBI; POS to send resident to ER r/t c/o not feeling well; consultant informed resident not able to return to facility due to behavior indicating potential risk to self & others & facility unable to adequately meet resident's need at current time; Adm staff notified hospital that facility would not accept resident back; Notice of Discharge did not list the LTCO's email address; Administrative Staff A signed notice on 07/14/25; Adm stated representative informed that resident had multiple police interventions at hospital prior to facility admission as resident hitting people "left & right" & facility tried to refer resident to several places; Adm stated facility issued 30-day notice but resident already out of building*
- *Resident with MDD, repeated falls & generalized anxiety; "Social Services Note" on 07/16/25 at 12:54 PM, documented Zoom meeting held with resident & resident's insurance care team for resident's return back into community. Resident's insurance care team aware that resident received 30-day notice due to non-payment & discharge date was 07/31/25. During the meeting, resident*

had to be redirected at times due to accusations being made. Resident stated was looking into a place in another town. Resident's insurance care team asked if resident's 30-day notice could be extended, & were informed that corporate would make that decision. Resident stated did not have to leave if did not want to. Insurance care team discussed possibly getting funds for a motel until an apartment was available; Notice of Discharge did not list LTCO's email address

F628 Discharge Process

SE: SS=D: Failed to notify Ombudsman of 1 resident's admission to hospital, placing the resident at risk of impaired rights r/t transfers & discharge

- EMR documented resident transferred to hospital; EMR lacked documentation Ombudsman's being notified of transfer to hospital

SW: SS=D: Failed to ensure 2 residents/representatives were provided written notification of transfer upon residents' transfer to hospital placing residents at risk of miscommunication between facility & the resident's representative, & possible missed opportunity for healthcare services

- Facility lacked required written notification of transfer including where & why resident was transferred & was provided to resident/representative upon transfer to hospital on 2 occasions
- Staff reported no written form given to resident/representative of reason for transfer to hospital for 1 resident/representative

SW: SS=D: Failed to provide 1 resident a written notification of transfer to resident/representative as soon as practicable placing resident at risk of impaired rights r/t transfer & discharge

- NN documented resident to transferred to hospital; EMR lacked documentation of written notification to resident/representative explaining reason for transfer to hospital

SW: SS=D: Failed to provide 1 resident a written notification of transfer to resident and/or representative as soon as practicable

- EMR lacked documentation of written notification to resident/representative which explained reason for transfer to hospital; Adm nurse unaware of requirement to notify resident/representative in writing of reason for transfer to hospital & confirmed not done for resident's hospital transfer

NE: SS=D: Failed to document recapitulation of stay for 3 residents with risk for miscommunication of services received during the stay in the facility & if post-discharge care needs for affected residents

- *EMR lacked documentation of discharge summary including recapitulation of stay; LN stated had not been instructed on if facility had separate discharge summary separate than discharge instructions for multiple residents*

NE: SS=D: Failed to provide a final summary of resident's status at discharge for 2 residents placing residents at risk of delayed care or uncommunicated care needs

- EMR documented discharge MDS-return not anticipated; Discharge Charge Summary undated & lacked documentation showing recompilation of stay

Resident transferred to hospital; LN stated did not notify family/representative in writing; Adm Nurse stated SS provided written notification & bed hold sent with resident at time of transfer

NE: SS=D: Failed to ensure that 1 resident & representative were provided, as soon as practicable, a written notification of transfer upon resident's transfer to hospital; facility failed to ensure a discharge summary, & a recapitulation of 1 resident's stay was completed upon discharge from facility placing 2 residents at risk of miscommunication between facility & resident's representative, & possible missed opportunity for healthcare services

- EMR lacked documentation of Bed Hold or Notification of Transfer in record when resident hospitalized on multiple occasions
- NN documented resident discharged to home; facility unable to provide discharge summary including recapitulation of stay, a final summary of resident's status & reconciliation of all pre- and post-discharge meds

NE: SS=D: Failed to ensure 2 residents/representatives were provided bed hold & written notification of transfer, as soon as practicable, upon transfer to hospital; failed to ensure 1 resident/representative was provided bed hold, as soon as practicable, upon transfer from facility

- Adm nurse reported unaware of facility's policy for who was responsible for bed hold procedure due to being new to role of Adm nurse; record w/o evidence of bed hold provided to resident when hospitalized
- Resident hospitalized & facility failed to provide resident/representative with bed hold policy & written notification of transfer as required for resident/representative

NW: SS=D: Failed to ensure that facility provided a bed hold policy notice to 1 resident/representatives when resident transferred to hospital with risk of impaired ability to return to facility & to resident's previous room

- Failed to provide bed hold for 1 facility-initiated discharge as requested

NW: SS=D: Failed to provide resident/representative with bed hold policy when 1 resident was transferred to hospital placing resident at risk for uninformed care choices

- Record lacked evidence that either resident or representative notified of bed hold policy when resident hospitalized

NW: SS=D: Failed to provide a bed hold notice, as required, to 1 resident/representative upon discharge from the facility

- Record revealed resident discharged to hospital on 2 occasions; record lacked evidence resident/representative provided bed hold notice at time of each discharge

F636 Comprehensive Assessments & Timing

NE: SS=D: Failed to complete a thorough MDS for 1 resident when staff did not complete the analysis of findings for the triggered "Care Area Assessments" placing resident at risk for impaired care due to unidentified care needs

- CAAs lacked analysis of findings

F637 Comprehensive Assessment After Significant Change

NE: SS=D: Failed to identify significant change in 1 resident's condition & complete a comprehensive "Significant Change MDS with discontinuance of hospice services

- Quarterly MDS of 2-23-24 documented resident received hospice services; Annual MDS of 5-23-24 documented resident did not receive hospice services; quarterly MDS of 2-23-25 documented resident received hospice; record lacked evidence facility completed sig change MDS to address resident's DC of hospice services; staff stated unaware that sig change MDS needed to be done going off hospice services or going on palliative care services

F641 Accuracy of Assessments

SE: SS=D: Failed to accurately complete the MDS for 2 residents placing residents at risk for impaired care due to unidentified care needs

- Sig change MDS coded incorrectly r/t lack of documentation of 2 falls
- Quarterly MDS documented resident received anticoagulant; POS for ASA for antiplatelet

F655 Baseline Care Plan

NE: SS=D: Failed to develop a person-centered baseline CP for 1 resident to include resident's chronic pain placing resident at risk of impaired care r/t uncommunicated care needs

- Baseline CP lacked direction for resident's chronic pain r/t fx'd toe, Guillain-Barre syndrome & fibromyalgia

F656 Develop/Implement Comprehensive Care Plan (CP)

SE: SS=D: Failed to complete a comprehensive CP for 1 resident regarding non-pharmacologic pain interventions & for 1 resident regarding O2 use placing residents at risk for impaired care due to uncommunicated care needs

- CP lacked staff instruction for non-pharmacological interventions for pain
- CP lacked staff instruction r/t O2 use

F657 Care Plan Timing & Revision

SE: SS=D: Failed to update 1 resident's CP, putting resident at risk for inadequate care due to uncommunicated care needs

- *CP documented resident could, at times, make false accusations against staff & was on psychotropic meds to regulate emotions & thought patterns; resident receiving psychiatric services thru telemedicine; CP instructed staff to provide "care in pairs"; observed staff provided assist while toileting resident & no other staff in room at time of care; CNA stated unaware of need to provide care in pairs*

SE: SS=D: Failed to review & revise CPs 1 resident r/t non-pharmacological interventions for pain, placing resident at risk for unrelieved pain due to uncommunicated care needs

- EMR with dx of pain; MDS indicated resident with scheduled pain meds with no non-pharmaceuticals attempted; CP lacked non-pharmacologic pain interventions

NW: SS=D: Failed to revise 4 sampled residents for interventions r/t antihypertension medications placing residents at risk for physical decline, other related complications, & at risk for unnecessary medications

- CP lacked direction to staff r/t interventions r/t antihypertension meds & to provide direction to staff r/t administration parameters for 1 resident's Amlodipine medication
- CP care plan lacks direction to staff regarding interventions r/t antihypertension medications CP further failed to provide direction to staff for resident's amlodipine (an antihypertensive) medication r/t administration instructions for BP parameters

NW: SS=D: Failed to revise CP for 1 sampled resident which included interventions for antihypertensive meds placing residents at risk for physical decline, other related complications, & at risk for unnecessary medications

- CP lacked direction to staff r/t interventions r/t antihypertensive meds; CP failed to provide direction to staff r/t resident's Metoprolol

NW: SS=D: Failed to review or revise 1 resident's CP with new effective interventions after each fall

- Resident with high fall risk & hx of falls; multiple documented falls; fall note for 1 fall with no intervention to prevent further falls documented; 1 CP fall intervention to "obtain lab work" & staff verified not immediate fall prevention intervention

NW: SS=D: Failed to implement individualized person-centered interventions to prevent falls for 1 resident after fall

- Resident with dementia, anxiety, MDD, HTN; dependent for ADLs; CP lacked resident-centered interventions to prevent further falls; EMR lacked Fall Risk Assessment that was completed for resident before or after fall; incident report documented resident with fall when staff lowered resident to floor during walking with walker resulting in skin tears; observed staff walking with resident with gait belt with 1 staff present; CP lacked effective intervention following falls

F676 Activities Daily Living (ADLs)/Maintain Abilities

SW: SS=D: Failed to offer & provide assistance with grooming of facial hair for 1 resident who participated in hygiene activities but needed staff assistance

- CP lacked documentation for personal hygiene assist or preferences for resident; observed resident & interview resident with several long facial hairs on face ½ long & resident reported did not know had long facial hairs & stated did not like having facial hair; observed resident later with continued long facial hair;

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to provide nail care for 1 resident

- Resident with dementia; Observed resident with long, dirty fingernails

NE: SS=D: Failed to ensure that cleaning of resident's mouth was provided for 1 resident who required assistance from staff to complete care placing resident at risk for complications, including discomfort related to poor personal hygiene

- Resident with tube feeding; CP documented resident with oral/dental health problems r/t poor oral hygiene & was NPO; CP to provide mouth care to be provided at least daily; observed resident in bed with thick yellow substance on lips & in mouth

NE: SS=D: Failed to provide consistent bathing for 2 residents with risk of poor hygiene & decreased self-esteem & dignity for affected Residents

- *Documentation Survey Report for 5-1-25 thru 8-5-25 revealed bathing "not applicable" on 19/28 scheduled bathing days & resident unavailable on 1/28 scheduled bathing days & blank documentation for 8/28 scheduled bathing days; observed resident with slightly greasy hair & debris on gown & resident stated last shower was previous week & not getting showers regularly & would like more showers regularly & not getting showers made resident feel dirty; CNA stated struggled to get bathing done recently*
- *Documentation Survey Report for 5-1-25 thru 8-5-25 documented bathing 9/28 scheduled days with 6/28 documented as "not applicable" & 4/28 "unavailable" & 9/28 blank; report documented shampoo on 4 scheduled days during time period; observed resident with hair greasy & resident stated did not get enough showers & wanted more*

NW: SS=D: Failed to ensure 1 resident was showered/bathed according to resident's preference, 2x/wk

- EMR documented resident had 1 shower in 12 days since admission to facility; observed resident with unclean, unkempt hair & resident with distinct odor of urine & resident stated had not had but 1 shower since admitted to facility & resident stated felt dirty, unclean & felt like resident smelled

F679 Activities Meet Interest/Needs Each Resident

NW: SS=E: Failed to provide direct, interactive activities based on resident preferences on weekends placing affected residents at risk for decreased psychosocial well-being, boredom, & isolation

- Activity Calendar for June, July, August 2025 completed & resident only had access to activity cart on Saturdays for self-led activities & only provided televised church service on Sundays; no other activities listed for weekends for residents; Resident Council reported facility lacked consistent activities on weekends r/t lack of staff present

F684 Quality of Care

NE: SS=D: Failed to ensure staff monitored & reported lab results to provider as they became available in order to treat 1 resident's UTI placing resident at risk of ongoing pain with urination, agitation, & confusion r/t delayed treatment of UTI

- *CP lacked interventions r/t UTI; NN documented resident reported "burning" when urinating & POS verbal order for UA with C&S; urine culture ID'd E. coli & listed ABT which bacteria was sensitive to & resistant to & 3+ leukocytes but no C&S found; progress note documented provider requested nurse check with lab for C&S & UA culture not seen nor reported to provider in results & results not "flagged" in EMR; resident's confusion & agitation continued; POS with order for IV ABT*

NE: SS=D: Failed to consistently follow a physician's order for daily weight monitoring for fluid overload & further failed to ensure 1 resident's fluid restriction was monitored per physicians' orders

- POS for daily weights with notification parameters; POS for fluid restriction; EMR documented weights obtained every Monday, Wednesday & Friday & EMR lacked weights for Tuesday, Thursday, Saturday & Sunday; EMR lacked documentation of meals consumed daily

NW: SS=D: Failed to ensure that staff followed a physician's order to obtain a daily weight on 1 resident who had CHF placing resident at risk for unwanted weight and fluid gain

- POS for daily weight r/t CHF; TAR revealed staff failed to obtain resident's daily weight on 12/31 opportunities in March, 2025, 8/30 in April, 3/31 in May, 2/16 in June

NW: SS=D: Failed to complete a physical assessment on 1 resident who displayed signs of choking during supper meal

- CP documented resident with swallowing issues & instructed staff to provide direct supervision at mealtimes; POS for regular diet, liquidized texture, nectar thick, mildly thick diet; incident report documented CNA noticed resident drooling & reported to LN & instructed resident to take a drink of milk then put food into resident's mouth then documented LN stated resident was fine & walked to another area of DR & CNA documented resident continued to drool & had blank stare then CNA donned gloves, went to resident & asked resident question to which resident grunted then told resident to spit out food that was in mouth & resident

unable to the CNA put finger into resident's mouth to help get food out & did that multiple times until resident's mouth was empty & LN stood by & did not assist CNA; EMR lacked documentation that physical assessment completed after incident or continued concern; incident not documented in EMR or follow up of incident documented in EMR

F686 Treatment/Services to Prevent/Heal Pressure Ulcer (PU)

NE: SS=D: Failed to ensure pressure-reducing measures were placed on 1 residents' bilateral lower extremities to prevent PU placing resident at increased risk for PU development

- POS for bilateral boots when in bed with tx orders; observed resident in bed with heels directly on mattress w/o boots

NE: SS=D: Failed to ensure 1 resident's low air loss mattress was at correct weight setting, & 1 resident's offloading boots were applied to resident's heels to prevent pressure ulcers placing 2 residents at increased risk for developing PUs

- Resident with 1 stage 3 PU documented on MDS; CP lacked direction to staff to monitor low air-loss mattress; resident's weight 213.6 #'s; observed low air-loss mattress set at 550 #'s on multiple occasions; CNA stated did not do anything with low air-loss mattress but would ensure it was working & knew nothing about dials
- Resident at risk for skin impairment; CP documented staff to offload bilateral heels using multiple pillows or soft heel lift boots when in bed as resident would allow; observed resident on multiple occasions with heels laying directly on mattress

NE: SS=D: Failed to monitor the low-air-loss mattress for 1 resident & further failed to provide a pressure-reducing device for1 resident's w/c

- POS for low air loss mattress & pump function q shift; resident's weight 128.6 #s; mattress set at 240 #s; CNA stated staff checked mattress to ensure mattress in working order, plugged in & set at correct weight
- CP instructed staff to place redistribution devices on bed & in w/c; observed resident's w/c lacked cushion in chair & none in room on multiple occasions; observed resident in w/c & lacked cushion in w/c & hand closed & lacked splint & foot slid along floor under w/c as resident propelled self with hand

F688 Increase/Decrease in ROM/Mobility

NE: SS=D: Failed to ensure 1 resident was given ROM exercises to prevent contractures & help with resident's flaccid left hand leaving resident at risk for further decline & decreased ROM or mobility

- CP documented nursing & restorative aide to perform active ROM to bilateral lower extremities for 20 minutes; EMR documented no indication ROM exercises were performed & no refusals; LN stated facility w/o restorative CNA & has been understaffed & RA pulled to floor to work as CNA & unable to do restorative duties

NE: SS=D: Failed to ensure 1 resident was provided services & treatment to prevent worsening of contractures in left hand placing resident at risk for discomfort & decreased range of motion

- Dx of contracture of lt elbow, lt hand & dementia; MDS documented resident w/o nursing restorative program; EMR lacked documentation of re-eval of current hand/elbow contracture & lacked documentation of alternative interventions or services provided to resident to prevent worsening of contractures; EMR lacked documentation of refusals to wear hand splint; observed resident w/o splint or device on multiple occasions

NE: SS=D: Failed to ensure 1 resident received services & treatment for right-hand contracture to prevent an avoidable reduction of ROM

- Resident with dementia, muscle weakness, contracture of hand, hemiparesis/hemiplegia, CVA; MDS indicated limited ROM upper & lower on 1 side; CP documented resident to wear hand brace during morning & removed at bedtime as tolerated; POS for hand splint in AM & remove at bedtime daily; observed resident propelling w/c & w/c lacked cushion in w/c & hand tightly closed & lacked splint & foot slid along floor under w/c as propelled self with affected hand

NW: SS=G: Failed to provide restorative nursing services to prevent further decrease in ROM for 1 resident's left hand, which had limited Mobility resulting in actual harm when resident had significant decrease in ROM to the left hand, could not mobilize wheelchair w/o staff assist, voiced concern that orthopedic surgeon would have to rebreak resident's hand to repair it, & voiced pain in left hand at all times

- MDS documented resident w/o any ROM services with restorative nursing therapy during look-back period; MDS noted no functional limitation in ROM; CP lacked any other restorative services except walking; CP documented resident with alteration in musculoskeletal status r/t fx's at base of proximal phalanx of left hand & acute fx of lateral radial styloid of left hand from fall; CP documented resident to wear brace on left arm until follow up orthopedic follow up (2-4-25); & brace order DC'd on 2-24-25 with new order for specialized brace to lt wrist & follow up appt revealed order for OT for gentle finger ROM x 3 weeks then gentle wrist ROM; after DC from OT, OT recommended resident for restorative ROM program; May 2025 documentation revealed staff performed ordered ROM 13/31 days, June 11/30 days, July 2/31 days; EMR lacked documentation staff performed ROM in August 2025 & restorative aide DC'd task on 8-5-25; resident stated hand "frozen" & could not move fingers & thought Dr was going to have to re-break hand & fingers to get hand back to normal & stated hand hurt "all the time"; observed resident with hand wrapped in blanket & stated could not do much with hand, it was cold & hurt all the time; resident stated could not use hand to propel w/c; OT stated resident DC'd from therapy because left hand was functional & placed resident on restorative ROM program & unaware resident not longer on restorative program

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=D: Failed to provide environment free of accident hazards when CNA assisted cognitively impaired resident with locomotion in hallway w/o use of w/c pedals placing resident at risk for accidents

- Observed CNA assisted resident & w/c w/o foot pedals & resident's feet off floor during assisted w/c locomotion

SW: SS=J (Past Non-Compliance): Failed to ensure environment free of accident hazards for 1 resident when CMA transported resident in facility van w/o safely securing resident with seatbelt in resident's w/c

- On 05/08/25 CMA abruptly applied brakes to avoid a collision, causing resident to slide out of her chair & fall on floor, with leg bent behind her; resident cried out in pain as EMS & facility staff removed resident from van; EMS transported resident to the hospital via ambulance & resident had severe pain, though the X-rays revealed no injuries; facility's failure to ensure staff safely secured resident with seatbelt in a moving vehicle placed resident in immediate jeopardy
    - Plan of Removal for Past Non-Compliance:
        - Installed seatbelts in facility's transport van
        - Staff instructed on how to use seatbelts
        - QAPI review of incident

SW: SS=D (Past Non Compliance): Failed to provide sufficient supervision for 1 resident to prevent resident from exiting building after an employee placing resident at risk for elopement, falls, & injury

- "Facility Incident Report," dated 03/24/25, documented on 03/22/25 at 06:58:50 PM, resident was at front door (which is where resident usually sits, & this is norm) & informed a PRN therapist staff resident could go outside. The therapist staff member attempted to open the door, but resident's WanderGuard kept locking the door down because resident was so close. At 07:00:11 PM, the PRN therapist staff opened door by inputting code, & therapist & resident went out doors together. The PRN therapist staff went to vehicle in parking lot & left. Approximately 5 minutes later, unknown family member went to nursing station & asked if gentleman in w/c should be outside. LN G looked at monitor, & screen had not turned orange, which indicated an elopement. At 07:07:20 PM, resident was brought back inside by the charge nurse. Resident was pedaling in w/c in middle of the parking lot. LN asked resident what resident was doing, & resident said was waiting for friend. Resident was unharmed upon assessment
    - Plan of Removal:
        - All staff education on elopements
        - Started teachable moments in person individually
        - Reviewed facility's "Elopement Policy & and Procedure,"
        - Completed competency checklists on elopements
        - On 03/24/25, signs were placed at all exits to ensure staff were notifying the correct people due to malfunctions in the call light system (elopement).
        - On 03/25/25, a message was out to call light/alarm company to address the following malfunctions:
            - 1. The front door did not make staff put in the elopement code as well as the normal code (new keypad ordered and installed).
            - 2. Front door not alerting the call light monitors that there was an elopement fixed.
            - 3. Front door not alerting pagers there was an elopement, as it should – fixed.
            - 4. Sound monitors on the 2 hallways not working – fixed.
            - 5. Front desk could still push remote button to open the door even when elopement beep sound was going off – fixed

SW: SS=D: Failed to follow care planned interventions to prevent falls for 1 residents

- Resident with fx ft femur at fall risk; CP documented staff to use 2 person assist for transfers; Incident report documented resident with fall off bed onto floor & body pillow not in use as it was on other bed in room; resident stated fell out of bed several times due to being restless & tossing & turning when slept; observed staff assisted with pivot transfer from bed using gait belt & resident started to fall & staff assisted resident to turn & plop into recliner then assisted to sit properly in recliner
- Resident with fall risk; CP instructed staff to ensure walker in reach & placing Dycem in chair & w/c; observed staff transferred resident from w/c & lifted resident using gait belt; walker against wall on other side of room & w/c w/o Dycem; staff unaware resident a fall risk & unaware of CP interventions

SW: SS=D: Failed to implement interventions to prevent further falls after fall for 2 residents

- Resident with BIMS of 7; resident with fall with injury & CP documented intervention was to remind resident to use call light; CNA stated nurse decided on interventions & CNAs not involved in process
- Resident with BIMS of 10; CP documented resident to wear O2 at all times; EMR documented resident with fall when resident standing to put in dentures & at time resident not wearing O2 & O2 sat was 89%; CP w/o updates for that fall; observed resident in BR, short of breath & w/o O2 on & staff member entered & assisted resident

NE: SS=E: Failed to secure 44 E pressurized medical oxygen tanks in a safe, locked area, & out of reach of the 8 cognitively impaired, independently mobile residents; further failed to ensure 1 resident's fall interventions were in place placing residents at risk for preventable accidents & injuries

- Observed O2 storage room with door unsecured & door with keypad & did not lock when door shut on multiple occasions
- Resident with cognitive communication deficit, dementia, hx of falls; observed room w/o traction tape or signage posted in room or BR as CPd

NE: SS=E: Failed to ensure O2 tanks were stored in securely locked room; facility failed to ensure 1 resident's NPO physician's order was followed placing residents at risk of possible avoidable injury

- Observed O2 storage room unlocked with 21-32 unused full O2 cylinders present on multiple occasions; staff reported lock broken & had been broken for 2 years

- Resident with dysphagia, oropharyngeal phase; POS for NPO & receives all nutrition thru feeding tube but ok for ice chips as requested; observed resident in room with cup of crushed ice in Styrofoam cup with spoon & no staff present; observed resident in room with cup of chunked ice with spoon & no staff present

NE: SS=J (Plan of Removal to D): Failed to ensure 1 resident, a quadriplegic resident with hx of traumatic brain injury, remained free from preventable accidents when direct care staff attempted to transfer resident in a Hoyer lift using incorrect sling

- On 08/04/25, 2 CNAs placed wrong-sized sling under resident in preparation of a Hoyer lift transfer; CNA staff attempted to lift but sling got caught on armrest of w/c; CNA staff were able to release sling from armrest, but still could not get resident to clear arms of the w/c; staff then attempted to lift resident up by pushing upwards from underneath resident while resident was still suspended in lift from the highest position; lift tilted, fell over, and resident fell to the floor; facility's failure to implement safe Hoyer lift techniques, including appropriate sling use to avoid accidents, placed resident in Immediate Jeopardy
    - Plan of Removal:
        - Provided verbal education with 2 CNAs involved in incident on 08/04/25
        - Facility's slings were replaced to ensure proper sizes on 08/04/25
        - Facility provided documentation of mechanical lift observations completed by administrative team from 08/05/25 to 09/17/25
        - All affected residents who required mechanical lift transfers were reviewed, & CPs updated as needed on 08/05/25
        - Administrative nursing team would audit three mechanical lift transfers weekly, starting on 09/15/25
        - Facility-wide re-education was started on 09/15/25 r/t safe mechanical lift transfers

NW: SS=D: Failed to provide sufficient supervision for 1 resident to prevent resident from exiting building placing resident at risk for elopement, falls, and injury

- *Resident with dementia & psychotic d/o; CP lacked interventions for wandering/elopement prior to incident; CP directed staff to call resident's wife when resident hallucinated; NN documented resident sat in common area watching Maintenance unwrap new fridge & who left to get a knife & when staff returned, staff saw resident outside in w/c on sidewalk by generator by leaving thru double door & staff & LN brought resident back in building & resident stated, "I was just looking around"; Wanderguard applied to resident's w/c; NN documented resident found sitting outside in w/c on grass looking at generator; Wanderguard did not activate; resident assisted back into building*

NW: SS=E: Failed to secure potentially hazardous cleaning chemicals in safe, locked area & out of reach of 9 cognitively impaired, independently mobile residents; additionally failed to provide adequate supervision & ensure 1 resident's fall prevention interventions were followed, resulting in multiple non-injury falls placing affected residents at risk for preventable accidents

- Observed main nurses' station with storage closet propped open by cloth sling rope & closet with multiple containers with warning labels; observed kitchenette with container in unlocked cabinet above sink with warning labels
- Resident with hx of falls & high fall risk; CP revealed resident with multiple falls with multiple fall prevention interventions; NN documented resident outside on patio with unwitnessed fall; observed resident with walker positioned next to resident & walked w/o ribbon as CP'd & "non-skid sock" signage behind flower pot

NW: SS=D: Failed to promote environment free of hazards for 1 resident who smoked cigarettes but was not assessed timely for safe smoking practices by facility, & kept smoking materials in nightstand beside bed placing resident at risk for avoidable injuries & fire-related hazards

- "Smoking Safety Screen" dated 11/25/24, documented resident required assistance to get to & from smoking area, but could light own cigarettes & put them out w/o assistance; assessment documented that resident smoked 2-5 times a day & could light own cigarettes & was safe to smoke w/o supervision; record lacked evidence facility had recently assessed resident for safe smoking practices including safe storage of smoking materials; observed resident in room; SSD stated resident smoked with staff & kept cigarettes in nightstand in locked box with KEY kept on necklace around resident's neck & had 2 packs of cigarettes in nightstand that not locked up

NW; SS=D: Failed to provide a safe environment with appropriate supervision to prevent falls for 2 residents

- CP lacked interventions r/t resident refusing help from staff with transfers or help in shower; incident note documented CNA called nurse r/t resident lying on floor in front of w/c & resident had been standing in front of shower chair then transferred self to w/c & when moved foot, slid out from under resident on wet floor & fell forward when resident fell to knees then went forward & caught self on w/c with inner sides of elbows & resident with bruising on bilateral inner elbows & abrasions on knees; investigation documented reason for fall was exhaust fan off so humidity seen on floor, possibly causing slick surface & intervention for fall was for staff to use extra safety measures when floor wet/humid; resident stated fell in shower because staff would not help resident transfer & is non-weight-bearing r/t ulcer on foot & difficult to transfer by self; resident stated never received any help from staff in shower room & feels that lack of staff support caused fall; Adm nurse stated resident refused all staff assist with transferring or bathing
- Resident dependent on staff for all ADLs; resident with high fall risk with multiple documented falls, 1 with no new intervention & 1 with inappropriate intervention of checking labs

NW: SS=D: Failed to provide a safe environment when facility failed to assess 1 resident for safe use of an electric recliner & failed to prevent a fall for 1 resident that resulted in skin tears

- Record lacked evidence that facility assessed resident for safe use of electric lift recliner; NN documented unwitnessed fall from electric lift recliner when resident slid out of chair when elevated all way in up position & resident landed on bottom on floor with no complaints of pain or discomfort during transfer
- EMR lacked Fall Risk Assessment completed for 1 resident before or after fall; incident report documented resident walked with walker out of BP, lost balance & started to fall when CNA turned to toss laundry bag to floor & CNA lowered resident to floor & resident hit nightstand sustaining 3 skin tears

F690 Bowel/Bladder Incontinence, Catheter, UTI

SE: SS=D: Failed to provide 1 resident who had indwelling catheter with appropriate treatment & services to care for a catheter & to prevent UTIs placing resident at risk for UTI & other catheter-related complications

- Resident with Foley catheter & dependent on staff for assist; observed 2 CNA/CMA using Hoyer lift & attached Foley to sling at resident's shoulder level above level of resident's bladder

NW: SS=D: Failed to obtain order for urinary catheter for 1 resident & failed to monitor urinary catheter output for 2 residents placing residents at risk for catheter-related complications

- Resident with urinary retention; CP documented resident to have catheter care q shift & I&O monitored per facility protocol; EMR lacked documentation resident had order for Foley catheter or documentation staff monitored I&O
- Resident with neurogenic bladder & hx of bladder cancer; record lacked documentation of urinary output for past 30 days; observed CNA empty catheter & stated did not document output because no where to put it

F692 Nutrition/Hydration Status Maintenance

SE: SS=D: Failed to provide ongoing assessment by RD for effectiveness of interventions & impact of nausea/vomiting on nutritional status for 1 resident who had experienced a significant weight loss & continued with insidious loss placing resident at risk for continued weight loss & malnutrition

- MDSs documented resident's weight dropped from 164#'s to 132#'s from 11-14-24 to 7-16-25; CP dated 7-30-24 documented resident's weight loss & staff to monitor, document & report; POS for weekly weight, no added salt, sugar-free diet, regular texture with regular, thin liquids order 8-14-25; protein supplements TID; EHR recorded an RD "Dietary/Nutrition Progress Note" dated 07/05/25 at 04:41 PM noting resident had nausea & vomiting for more than two days. The note documented resident's weight fluctuated & noted RD would check on resident at upcoming visit regarding nausea & vomiting per the DM & RD observations; weight documentation revealed weight 132.0 on 7-13-25 & 119.0 on 8-31-25; RD visit information provided by the facility for 08/11/25 lacked evidence that the RD assessed resident for continued weight loss & to evaluate effectiveness of nutritional interventions

NW: SS=D: Failed to consistently monitor 1 resident's physician-ordered fluid restriction placing resident at risk of complications related to fluid overload

- POS for 1800cc fluid restriction; CP updated to show resident would refuse fluid restriction at times & was aware of impact on health; Order DC'd on 8-5-25 & revised on 8-5-25; TAR lacked documentation of fluid restriction/fluid intake on 14 shifts from 6-1-25 thru 8-13-25; CNA unaware of how much fluid resident should be provided on shift

F693 Tube Feeding Management/Restore Eating Skills

SW: SS=D: Failed to ensure 1 resident, a resident who did not eat or drink, had a physician's order for the type of enteral feed formula to be administered through resident's G-tube &/or assessment & direction from RD until 6 days after admission

- Baseline CP documented staff to provide tube feeding of Jevity 1.5; hospital discharge orders lacked tube feeding/diet order; POS for Jevity 1.5 or any enteral feeding solution; POS lacked NPO order; resident admitted on 9-3-25 & RD order dated 9-9-25; observed feeding bag labeled with date & time hung but no other information on bag; RD confirmed nutritional assessment should be completed within 72 hours of admission

F697 Pain Management

SE: SS=D: Failed to administer pain meds for 1 resident who had dx of trigeminal neuralgia placing resident at risk of uncontrolled pain

- Resident with trigeminal neuralgia; pain CAA did not trigger; CP lacked direction to staff r/t non-pharmacological interventions for pain; MAR documented resident did not receive bedtime dose of Carbamazepine on 1 day, 2 doses on 1 day & morning dose on 1 day; MAR documented resident did not receive Lidocaine Viscous for last 2 scheduled doses on 1 day & 1st 2 scheduled doses on 1 day; EMR documented staff notified pharmacy of need to refill meds 1 day & 2x's next day; resident stated had not received pain meds over weekend & was experiencing increased pain

SE: SS=D: Failed to provide adequate pain management for 1 resident when staff failed to administer scheduled pain medication separate from medication that interfered with absorption & therapeutic effectiveness of resident's pain medication placing resident at risk for uncontrolled pain & decreased quality of life

- POS for Tramadol TID, Tylenol PRN, Misoprostol BID for pain, Diclofenac BID for leg pain, Carafate ac, Zofran ac, lactobacillus ac, Protonix daily; observed resident reported to CMA that resident had pain all over & rated her pain a 10 out of 10. CMA administered all of resident's medications together, including the tramadol, misoprostol, and diclofenac, following breakfast w/o regard for

physician's orders to administer 4 meds (Carafate, Zofran, Lactobacillus, and Protonix) before meals to prevent GI upset. CMA confirmed resident vomited frequently. CMA confirmed 4 medications were ordered before meals, & the meds that were ordered with food or after meals should not be given together with those to be given before meals. CMA verified that scheduled pain medications were scheduled & administered at the same time as 4 GI medications, even though the GI meds were ordered before meals to prevent nausea & vomiting at meals, which could interfere with effectiveness of pain meds

F698 Dialysis

NE: SS=D: Failed to ensure that 1 resident's dialysis physician order was in his orders of EMR; facility failed to ensure 1 resident's CP provided interventions to direct staff & implement care & services according to professional standards of practice in order to meet resident's dialysis care needs placing resident at risk for missed dialysis visits & complications related to dialysis

- CP lacked staff direction on dialysis days, location of dialysis clinic, contact information of dialysis clinic & how information would be communicated between facility & dialysis clinic; EMR lacked physician order for dialysis

NW: SS=D: Failed to ensure ongoing fluid restriction implementation for 1 resident who received dialysis treatment placing resident at risk for complications & health decline

- Resident with dialysis with fluid restriction of 2000cc per day; record w/o physician order for standing order for fluid restriction;

F699 Trauma Informed Care

NE: SS=D: Failed to assess & ID trauma-based triggers r/t 1 resident's PTSD; facility failed to implement individualized interventions to prevent re-traumatization to 1 resident placing resident at risk for decreased psychosocial well-being & ineffective treatment

- Active dx of PTSD with BIMS of 15; CAAs lacked PTSD addressed; CP lacked staff direction on PTSD triggers & interventions to prevent re-traumatization

F725 Sufficient Nursing Staff

NW: SS=F: Failed to ensure sufficient staffing placing affected residents at risk for decreased psychosocial well-being, boredom, & delayed care

- PBJ report documented excessively low weekend staffing for 3 quarters; CMA stated staff often busy completing cares for resident & activities not always completed on Saturdays or Sundays; CMA stated secured unit only had 1 or 2 staff members & often had difficulties providing supervision while performing care; Resident Council reported facility lacked consistent activities on weekends due to lack of staff present & direct care staff already struggling to complete resident care, but would not have enough staff to cover weekend activities; Resident Council reported long call light wait times & delayed care on weekends due to low staffing

F726 Competent Nursing Staff

NE: SS=E: Failed to verify & utilize appropriate Hoyer lift sling while transferring 1 resident resulting in non-injury fall from the Hoyer lift

- Cited findings noted in F689 r/t use of inappropriate lift sling resulting in fall

F727 RN 8 Hrs/7 days/Wk, Full Time DON

SW: SS=F: Failed to provide RN coverage for at least 8 continuous hours daily

- Nursing schedules for 4-1-24 thru 12-31-24 revealed lack of RN coverage for 8 continuous hours on 23 occasions & RN payroll documented lack of RN coverage same dates; Adm stated facility w/o RN coverage on days listed & issue ID'd & since improved

F730 Nurse Aide Performance Review-12 hr/yr In-Service

SE: SS=F: Failed to complete annual performance evaluations for 5 CNA who were employed at facility for more than 12 months placing residents at risk for decreased quality of care

- Review of personnel files for 5 CNA/CMAs shoed all 5 did not have performance evals completed for last 12 months of full-time employment

SW: SS=F: Failed to complete annual performance review at least once every 12 months for 2/5 CNAs reviewed, to ensure adequate appropriate cares & services provided to residents of the facility

- Review of CNA personnel filed revealed 1 CNA & 1 CMA lacked annual performance evals

F732 Posted Nurse Staffing Information

SE: SS=C: Failed to display accurate & identifiable staffing information, which contained actual nursing hours worked, for all residents who resided in the facility

- Daily staffing Report from 7-10-25 thru 8-10-25 revealed actual hours worked not completed on daily nurse staffing report

SE: SS=C: Failed to display accurate, publicly accessible staffing information that contained number of actual nursing hours worked on a daily basis, for all residents residing in the facility

- Review of Daily Staffing Sheets from 8-16-25 thru 9-9-25 revealed actual hours worked not completed on daily staffing sheets

SE: SS=C: Failed to display accurate & identifiable staffing information on daily basis

- Review of Daily Staffing sheets w/o actual hours completed

SW: SS=C: Failed to ensure daily staff posting included actual hours worked by nursing staff as required

- Observed daily staff posting document lacked documentation of actual hours worked; furthermore difficult to read titles of CNA, LPN, & RN above columns for shifts

NE: SS=C: Failed to ensure the posted daily nurse staffing sheets included accurate & identifiable information to include daily licensed & unlicensed staff actual worked hours

- Observed daily staffing sheet did not list actual number of hours worked; also posted were daily staffing sheets for 2 previous days which also lacked actual hours worked & no staffing sheets in August 2025 listed actual hours worked

F742 Treatment/Services Mental/Psychosocial Concerns

SW: SS=D: Failed to provide 1 resident who had a mental disorder & adjustment difficulties, with treatment & services to attain highest practical mental & psychosocial well-being

- Resident with dementia with behavioral disturbance, MDD, dizziness & giddiness; CP lacked SS-specific interventions r/t psychosocial needs; POS for Quetiapine for dementia with behavioral disturbance; Social Service staff reported that Licensed Master Social Worker was contracted, did not come to the facility, & reviewed electronic charting. Social Service reported had not received guidance from LMSW r/t behavioral aspects of residents, & no mental health provider sees resident in person or via telehealth consultations

F744 Treatment/Service for Dementia

SW: SS=D: Failed to ensure staff provided necessary person-centered activities & interventions to address 1 resident's dementia dx placing resident at risk of ineffective treatment & decreased quality of care

- Resident with dementia with psychotic disturbance, anxiety, delirium; CP lacked individualized, person-centered interventions r/t dementia care; observed resident in w/c in TV area with other resident & resident sleeping with head down toward chest; CNA stated had completed dementia training & education on Relias but had not received specialized training on behaviors specific to dementia; LN stated CP not specific & person-centered

NE: SS=D: Failed to provide consistent dementia-related behavioral interventions for 1 resident to promote resident's highest practicable level of well-being placing resident at risk for decreased quality of life, isolation, & impaired dignity

- Resident with dx of dementia with BIMS of 3; CP lacked interventions r/t inappropriate touching or boundary concerns prior to 9-2-25; NN documented resident observed holding hands with another resident & using affectionate gestures to other residents on secured unit; NN documented resident wheeled self around secured unit & observed repeatedly touching other resident; NN documented resident observed touching resident in sexual way & provided several redirections & resident became aggressive upon redirection & wanted to hit staff & staff moved resident to room; resident hospitalized r/t promiscuity & inappropriate behaviors; upon return documentation indicated resident continued with sexual behaviors; Adm staff stated did not view behaviors as sexual; staff reported resident transferred to all-male unit r/t increased behaviors

F755 Pharmacy Services/Procedures/Pharmacist/Records

SE: SS=E: Failed to ensure accurate & adequate system for monitoring & reconciliation of narcotic medications in the facility E-kits putting residents at risk of misappropriation of meds

- *Observed med room with narcotic E-kit containing multiple scheduled drugs; lock-out tag number did not match number documented on "Controlled Medication Shift Count"*
- *E-kit with multiple scheduled drugs & lock-out tag number did not match number documented on "Controlled Medication Shift" Count*
- *Review of count sheets in med room revealed staff signed off on count & reconciliation of E-kits 3 times from 6-1-25 thru 7-1-25; LN stated E-kits in med room not checked & documented by oncoming & off-going nurses at shift change*

NE: SS=F: Failed to ensure accurate reconciliation of controlled drugs at end of daily work shifts & maintain staff count sheets for controlled drugs placing residents at risk for misappropriation of medications &/or diversion of controlled substances

- On 09/09/25 at 07:30 AM, a review of the September 2025 "Narcotic Shift Count Sheet" on 1 hall from 09/01/25 to 09/09/25 revealed a missing signature either for on-coming nurse or off-going nurse on the following dates: 09/01/25, 09/02/25, 09/03/25, 09/04/25, 09/05/25, 09/06/25, 09/07/25, 09/08/25, and 09/09/25

F756 Drug Regimen Review, Report Irregular, Act On

SE: SS=D: Failed to acknowledge &/or act on consultant pharmacist's (CP) recommendation to resolve identified irregularities for 1 resident r/t anticoagulant med placing resident at risk for unnecessary meds & related complications

- POS for Xarelto r/t hx of stroke; MRR documented Xarelto added to Beers Criteria r/t increased risk of serious bleeding compared to other anticoagulants for elders with recommendation to DC with alternatives offered; record lacked evidence facility obtained response from physician to follow up to MRR for 42 days after initial recommendation

SW: SS=E: Failed to ensure the Consultant Pharmacist (CP) ID'd & reported to DON & Medical Director for 4 residents for appropriate use of antipsychotics; facility furtherly failed to ensure CP ID'd & reported to DON & Medical Director the missed vital signs required for 2 resident's heart meds placing residents at risk for inappropriate use of meds & unnecessary medications

- Cited findings in F605 r/t antipsychotics with inappropriate dx's (dementia)
- POS for Metoprolol Succinate for a-fib with notification parameters for heart rate & BP; MAR documented resident's BP & pulse not documented on 31/31 occasions in May, 30/30 in June, 31/31 in July & 26/26 in August; MRR lacked recommendation for BP or pulse monitoring for Metoprolol
- POS for Digoxin & a-fib; MAR documented pulse not obtained 31/31 occasions in May, 30/30 in June, 31/31 in July & 27/27 in August; MRR lacked recommendation for pulse monitoring for Digoxin use

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported irregularities regarding lack of monitoring antihypertensive medications for 1 resident placing resident at risk for adverse medication effects & unnecessary meds

- POS for Toprol XL for HTN; MAR reviewed from 5-1-25 thru 8-19-25 lacked consistent heart monitoring for Toprol; MRRs from 8-24 thru 7-25 lacked documented recommendations for heart monitoring & hold parameters & physician notification; LN stated POS lacked physician-ordered parameters

NE: SS=D: Failed to ensure the Consultant Pharmacist (CP) recommendations had been reviewed & addressed by physician within 30 days for 2 residents; also failed to ensure the CP had ID'd & reported physician-ordered lab tests had not been followed for 2 residents

- POS for CBC, CMP, & Vitamin B12 level yearly, Vitamin D level annually, Valproic Acid level quarterly q 3 months, Keppra level quarterly, HgbA1C, T4, TSH & Vitamin D level annually; Keppra, CBC, CMP & Valproic acid q 3 months; MRRs from 9-24- thru August 2025 lacked documentation or recommendations for lack of physician-ordered laboratory tests; . Review of resident's EMR under the "Misc" tab lacked MMRs from October 2024 and December 2024; facility was able to provide the MMR's on 09/16/25, which were reviewed by physician and dated 09/16/25; EMR under the "Misc" tab under "Laboratory" lacked test results, & facility was unable to provide evidence of results for the following laboratory tests, CBC & CMP, from May 2025 & August 2025; resident's EMR also lacked Keppra levels & Valproic acid level lab test from April 2025 & July 2025; EMR also lacked results from yearly lab work
- Review of the MMR from September 2024 to August 2025 lacked documentation or recommendations for lack of physician-ordered lab tests; review of resident's EMR under the "Misc" tab lacked MMRs from December 2024 & April 2025; facility was able to provide the MMRs on 09/16/25, which were reviewed by physician & dated 09/16/25; EMR under the "Misc" tab under "Laboratory" lacked test results, & the facility was unable to provide evidence of results for the following laboratory tests: Vitamin B12, T4, TSH, and Vitamin D level from yearly lab work in April 2025; EMR also lacked evidence of results from Haldol level in March 2025 & June 2025; EMR also lacked evidence of results for CBC & CMP from March 2025

NW: SS=E: Failed to ensure that staff followed a physician's order to obtain a daily weight on 1 resident with CHF; facility failed to ensure that 1 resident had specified dosage amounts for topically applied medication; failed to follow physician-ordered parameters for 2 resident's BP medication placing residents at risk for unwanted weight & fluid gain, and 3 residents at risk for unnecessary medication administration & related complications

- Cited findings noted in F684 r/t lack of daily weights as physician-ordered; MRR lacked ID & notification of issues
- POS for Voltaren gel & order lacked specific dosage; MRR lacked ID & notification of issue
- Cited findings noted in F657 r/t lack of administration of antihypertensive medications based on physician-ordered BP parameters for multiple residents; MRR lacked ID & notification of issues

F757 Drug Regimen is Free from Unnecessary Drugs

SW: SS=D: Failed to ID missed vital signs required for 1 resident's Metoprolol Succinate med & 1 resident's Digoxin placing residents at risk for unnecessary medications

- Cited findings noted in F756 r/t lack of monitoring of VS for cardiac meds

SW: SS=D: Failed to act upon blood sugar monitoring for 1 resident when staff administered insulin that should have been held per physician ordered parameters

- POS for Humalog with notification parameters for blood sugar levels & holding parameters for refusal of meals; MAR documented blood sugar outside notification parameters but insulin administered on 7 occasions;

NE: SS=D: Failed to follow the pharmacist's recommendation for the monitoring of antihypertensive meds for 1 resident placing residents at risk for adverse medication effects and unnecessary medications

- Cited findings noted in F756 r/t lack of BP monitoring for Toprol; POS lacked physician-ordered parameters

NE: SS=D: Failed to follow physician-ordered parameters regarding medication monitoring for 1 resident placing resident at risk for medication-related complications & adverse effects

- *POS for Amlodipine Besylate, Propranolol, Hydralazine with holding parameters for pulse & BP; POS for blood sugars with administration parameters for insulin; MAR revealed Amlodipine & Propranolol administered outside ordered parameters on 4 occasions in June; 6 times in July & Glimepiride administered outside parameters on 7 occasions in June, 3 times in July & insulin 2x's in July*

NE: SS=D: Failed to ensure 1 resident's insulin was given before meals according to physician-ordered parameters r/t blood glucose monitoring placing resident at risk for hypoglycemia, delayed treatment, & unnecessary medication complications

- Resident admitted on 7-4-25 & discharged to hospital 9-1-25; observed staff administered insulin that was ordered with meal, after meal; POS for insulin with meals with holding parameters; TAR documented 21 occasions when insulin administered outside holding parameters

NE: SS=E: Failed to ensure physician-ordered laboratory tests were obtained as ordered for 2 residents also failed to consistently take & record BPs & pulse for 1 resident's beta blocker

- Cited findings noted in F756 r/t lack of physician-ordered labs for 2 residents
- POS for Coreg with holding parameters for pulse & BP; TAR lacked evidence BP obtained on 7 occasions in Sept, 2025

NW: SS=E: Failed to ensure staff clarified 1 resident's Voltaren physician order when order lacked location or dosage amount in directions; failed to ensure staff monitored 2 residents' BP prior to administering antihypertensive med placing 3 residents at risk for unnecessary medication administration & related complications

- Cited findings noted in F756 r/t Voltaren gel order lacking dosage & location & 2 residents with physician ordered parameters & staff failed to monitor BP prior to administration

NW: SS=D: Failed to hold BP medication per physician's ordered parameters for 1 resident placing resident at risk of low BP & pulse side effects, & at risk of receiving unnecessary medication

- POS for Metoprolol for HTV with holding parameters for BP & pulse; MAR revealed 7 occasions from 7-18-25 thru 8-20-25 with pulse outside holding parameters & med was administered; CMA stated did not usually worry about heart rate & focused on BP

NW: SS=D: Failed to notify physician when 1 resident's blood sugar was out of physician-ordered parameters & failed to hold 1 resident's hypertension medication when resident's diastolic blood pressure was out of parameters

- POS for Lisinopril with holding parameters; MAR documented resident received drug when BP out of holding parameters on 4 occasions July thru Sept; POS for notification parameters for blood sugar results & MAR documented 6 occasions July thru Sept when physician not notified of blood sugar levels as ordered

F759 Free of Medication Error Rates of 5% or More

SE: SS=E: Failed to ensure a med error rate of less than five % when staff administered 4 meds in error resulting in medication error rate of 17% placing residents at risk of ineffective medication regimens

- Cited findings noted in F697 r/t failure to follow recommendations for administration of meds timing r/t meals

NW: SS=D: Failed to prevent a medication error for 1 resident whose BP was out of physician's ordered parameters, & resident received 2 BP meds placing resident at risk of physical decline & other related complications

- POS for Losartan with notification parameters with multiple days in multiple months when med administered outside ordered notification parameters; POS for Hydrochlorothiazide with holding parameters with multiple days in multiple months when med documented as administered when BP outside notification parameters; POS for Amlodipine with holding parameters with multiple days in multiple months when med documented as administered when BP outside notification parameters

F760 Residents are Free of Significant Med Errors

NW: SS=D: Failed to prevent medication errors for 4 sampled residents who received BP medication when out of physician-ordered parameters for several administrations over the last 3 months placing residents at risk for physical decline & other related complications

- Cited findings noted in F756, F757, F759 r/t administration of antihypertensives when BP outside physician ordered parameters

F761 Label/Store Drugs & Biologicals

SE: SS=D: Failed to ensure staff had properly secured storage of resident medications placing residents at risk of missing meds & ineffective medication regimens

- Observed in Environmental Services closet, delivery boxes on floor & 1 box contained multiple stock meds

SW: SS=D: Failed to store drugs & biologicals for 1 resident according to policy in the medication cart placing resident at risk for ineffective medication regimen

- Observed med cart with 1 resident's contained Lantus insulin pen w/o resident's name or date insulin pen put into use

NE: SS=E: Failed to secure medication at the nurse's station placing residents at risk for unnecessary medication & administration errors

- Observed bottle of ocular vitamins expired & left unsecured on counter at nurses' station

NE: SS=E: Failed to ensure medication cart was kept locked & secured with cognitively impaired & independently mobile residents on 1 hall placing residents at risk of accidental ingestion of medication & adverse reactions

- Observed med cart unlocked & unattended

NE: SS=F: Failed to secure medication carts containing residents' pens & needles, residents' scheduled medications, & over-the-counter medication

- Observed 4 med carts in common area unlocked & unsecured; observed med cart in hallway unlocked & unsecured

NW: SS=E: Failed to dispose of expired medications in timely manner placing residents at risk of receiving ineffective medication

- Observed med room with multiple expired stock meds

NW: SS=D: Failed to label & date 1 insulin pen after opening for use placing residents at risk for ineffective or outdated medication

- Observed med cart with 1 Novolog insulin pen unlabeled & undated

NW: SS=D: Failed to label 1 resident's insulin flex pens when initially opened for use & when expired

- Observed tx cart with resident's Novolog flex pen with open date & lacked expiration date & per 28 day effectiveness pen expired 4 days prior to observation

F801 Qualified Dietary Staff

SW: SS=F: Failed to employ a full-time CDM for all residents residing in facility & receiving meals from kitchen placing residents at risk of not receiving adequate nutrition

- Staff ID'd self as Dietary Manger, enrolled in CDM course but had not yet finished course & RD came to facility monthly

NW: SS=F: Failed to employ a full-time CDM for the all residents residing in facility & receiving meals from facility kitchen placing residents at risk for inadequate nutrition

- Dietary staff verified not certified but had passed course & just needed to take test & had many years in food service industry; Adm nurse stated waiting period before DM could take test

NW: SS=E: Failed to employ a full-time CDM for the residents residing in facility & receiving meals from facility kitchen

- Staff confirmed no CDM but dietary manager enrolled & started dietary certification classes

F802 Sufficient Dietary Support Personnel

NW: SS=E: failed to provide adequate number of dietary staff to serve residents, who received their meals in the dining room

- Observed dietary manager had temped food on steam table & was ready to serve residents' food & several residents in DR waiting for meal at 11:45am; at 12:15 staff came to serving window & notified dietary they were ready to serve food & dietary completed serving at 1:pm; staff reported scheduled time for noon meal was 11:30am but could not start serving resident until staff available in DR to serve food & only had 1 dietary aide who was also responsible for dishwashing; at 12:55pm 2 resident had not received meal trays

F804 Nutritive Value/Appear, Palatable/Prefer Temp

SE: SS=D: Failed to provide food that was nutritionally balanced, palatable, attractive, & at safe appetizing temperatures placing residents at risk for inadequate nutrition & decreased quality of life

- *Resident stated food could be better & usually opted to eat in room & food not hot as would like & "just makes do as don't want to bother staff"; resident stated always ate in room by choice & food "nasty & cold" & tells staff & they tell her it was hot when it left kitchen & had complained to nursing & kitchen staff & had not filed a written grievance but said staff knew concerns & nothing had changed; resident stated food was not worst food had eaten in life & was spoiled because had lived with chef & temp of most meals not totally cold but not hot either & staff heated food up if asked*
- *Observed room trays; test tray was last tray served from cart: casserole 127 degrees F; vegie119 degrees, cake 77 degrees then tray tasted by staff; staff confirmed cake was substitute; observed another hallway trays served in insulated meal cart & nursing staff not present to deliver meal trays so staff left cart in hallway to locate staff; Activity staff reported complaints about food almost monthly r/t temp & lack of options & food quality, texture, & palatability*

SW: SS=E: Failed to ensure meals were served at safe & appetizing temps as evidenced of 1/1 meal observation

- Observed staff prepared purred meals; food with cooked temp of 165 degrees F & 186 degrees F & temp after prep was 127 degrees F & 135 degrees F; staff; after placed on steam table, pureed foods was 115 & 120 degrees F & staff served foods to residents at lower temps

NE: SS=E: Failed to follow nutritionally approved recipes during preparation of facility's puree-based meals

- Observed staff placed meat in food processor & stated had added 1 cup beef broth then started machine then added several spoons of thickener powder into processor then checked consistency then placed steak into container then cleaned processor bowl then placed vegie into processor then stated had added chicken broth into processor then added several spoons full of thickener powder then placed vegie into pan; then cleaned processor bowl then place cake into processor & stated had added "about a cup" of milk for cake then added more milk then placed into metal pan & never used recipe during process; recipe lacked indication of servings & fluid measurement to be added

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=F: Failed to provide sanitary conditions for food storage & preparation to prevent spread of food-borne illness to residents of the facility placing residents at risk for food-borne illness

- Observed top of automated dishwasher with dried food debris; ice maker with food particles on top & sides of machine & food stored on top of machine; kitchen area had multiple fans placed throughout kitchen & fans dirty & dusty & blowing into food prep area & dish cleaning area; numerous food items & trash on floor; trash cans visibly dirty on outside; counter with spilled coffee; floors sticky & slick; cutting boards marked & grooved throughout cutting surface, 3 baking sheets with baked-on grease in each corner & cut marks throughout cooking surface; counter with coffee pots with spilled coffee & kitchen floor continued to be sticky; broken tile around clean-out drain by stove; automated dishwasher with debris; staff reported no regular cleaning schedule for automated dishwasher but should not be dirty; maintenance staff aware of broken tile but had not replaced it yet

SE: SS=F: Failed to prepare & serve food under sanitary conditions, to prevent potential for food borne illness & decreased palatability placing residents at risk for illness & weight loss

- Observed: freezer with unsealed meat & other food items; 4 cutting boards with deep grooves & scratches

SE: SS=F: Failed to store & prepare food under sanitary conditions for residents of facility placing residents of facility at risk for illnesses r/t food borne bacteria

- Observed handwashing sinks with stains & grime buildup around sink's inner & outer edges; foot-operated trash can with broken lid

SE: SS=F: Failed to store & prepare food in 1/1 kitchen under sanitary conditions placing residents of the facility at risk for food borne illnesses

- Observed prep table with rust & peeling paint next to surface; missing trim/door facing on 1 side of kitchen door exposing sheetrock surface; broken floor tiles in dry food storage area

SW: SS=F: Failed to prepare & serve food under sanitary conditions to prevent the potential for foodborne bacteria

- Observed satellite kitchen & staff removed container of lettuce from fridge with gloved hand then wearing same gloves, opened cabinet, removed bowls from shelf & closed door & with same soiled gloves, removed lid from lettuce container & grabbed handful of lettuce then turned on faucet, rinsed lettuce off & shut faucet off still wearing same gloves then squeezed lettuce & placed it back into each bowl then removed gloves & applied new gloves w/o hand hygiene then opened drawer, opened bag of cheese, scooped out shredded cheese, poured salad dressing into container, rinsed out container, removed gloves & applied new gloves w/o performing hand hygiene; observed other food contact with soiled gloves & changing gloves w/o performing hand hygiene

SW: SS=F: Failed to prepare & serve food under sanitary conditions to prevent potential for food borne bacteria placing residents at risk for food borne illnesses

- Observed: multiple food items in freezer open to air; 3 cutting boards with black substance around edges & grooves in boards; pans & bowls not inverted or covered

SW: SS=F: Failed to prepare & serve food under sanitary conditions to prevent potential for food borne bacteria placing residents at risk for food borne illnesses

- Observed unlabeled, undated food items; freezer & fridge with multiple unlabeled, undated food items; observed packaged bags of ham lunch meat, ground beef & sausage thawing above stove which contained pans of cut-up potatoes cooking;

NE: SS=F: Failed to follow sanitary dietary standards r/t overflowing trash & food storage placing residents at risk for food-borne illness

- Observed kitchen floor sticky; freezer with unlabeled & undated food items; freezer with opened & undated food items; trash bins overflowing with trash uncovered

NE: SS=F: Failed to prepare & serve food under sanitary conditions, to prevent the potential for food borne bacteria placing residents at risk of food borne illnesses

- Observed multiple carts with food debris & sticky areas; fridge with dried liquid & food debris; dressing with dried on dressing around top & sides of containers; prep table with food debris on shelf

NE: SS=F: Failed to follow sanitary dietary standards related to storage, preparation, & meal service placing residents at risk of food-borne illnesses & food safety concerns

- Observed: floor heavily dirty with old food debris & trash in food prep & stover area; soiled towel on floor next to stove top ovens; saucers & plates stored upwards in storage rack; dry storage area with soiled Band-aid on floor; dented can; fridge with tray of cold cuts with liquid dripping on packages from AC unit

NW: SS=F: Failed to store, prepare, distribute, & serve food by professional standards for food service safety in one kitchen placing residents receiving meals from facility's kitchen at risk for foodborne illness

- Observed: fridge with multiple unlabeled, undated food items; freezer with unlabeled, undated food items
- Observed wallpaper border behind oven & 3-sink area with numerous places with peeling paper; freezer with ice buildup on inside; missing piece of linoleum under dishwasher, walking area when entering dishwashing area; wall with bubbling, peeling paint; missing linoleum in front of 3-sink area; undated flour & sugar bin with numerous different-sized black speck around outside of bins

NW: SS=F: Failed to measure & record daily refrigerator & freezer temps for evening shift placing residents at risk for food-borne illnesses

- Observed daily temp logs for fridge & freezer lacked documentation on multiple days

NW: SS=F: Failed to store, prepare, distribute, & serve food by professional standards for food service safety in 1 kitchen placing residents receiving meals from facility's kitchens at risk for foodborne illness

- Observed: multiple unlabeled, undated food items; fridge lacked back-up thermometer
- Observed pipes under sink in dishwashing area with numerous areas of brownish stains; 13 vents under ceiling AC with gray fuzzy substance

F838 Facility Assessment

NW: SS=F: Failed to conduct a thorough facility-wide assessment to determine resources necessary to care for residents competently during day-to-day operations & emergencies

- Assessment ID'd required staffing needs per day but failed to ID specific staffing needs by shift for weekends; assessment failed to ID resident's acuity for care needs; assessment failed to provide a detailed emergency staffing plan in the event of emergent situations; consultant stated assessment previously provided to survey team not correct one & gave a new assessment stating "this is the actual facility assessment";

F849 Hospice Services

NE: SS=D: Failed to ensure coordinated plan of care, which coordinated care & services provided by facility with care & services provided by hospice, was developed & available for 2 residents placing residents at risk for inadequate end-of-life care

- Care Plan lacked staff direction on what hospice provided for resident as far as supplies, durable medical equipment (DME), medications, & hospice staff information for multiple residents

NW: SS=D: Failed to ensure a coordinated CP, which coordinated care & services provided by facility with care & services provided by hospice, was developed & available for 2 residents placing residents at risk for inappropriate &or unmet end-of-life cares

- CP lacked when hospice staff would be in building & what care & supplies hospice would provide for 2 residents

NW: SS=D: Failed to ensure collaboration between hospice provider & facility for 1 resident who was admitted to hospice on 08/28/25 placing resident at risk of inadequate end-of-life care

- CP lacked documentation of what supplies, meds & when hospice staff would be in building

NW: SS=D: Failed to include a hospice service visit frequency, medications, medical equipment, & preferences for 1 resident placing resident at risk of not receiving resident-directed end-of-life care

- CP lacked specifics of delegation of hospice staff services, visit frequency, medications, medical equipment & personal hygiene supplies; Adm Nurse stated hospice aide usually did not come because facility's staff met personal needs & staff lacked list of supplies furnished by hospice

F851 Payroll Based Journal

SW: SS=C: Failed to electronically submit accurate staffing information through PBJ

- PBJ documented facility failed to have RN coverage on 23 occasions 10-2-24 thru 3-4-25; PBJ report documented 6 dates w/o LN coverage 24 hrs/day; review of documentation revealed days listed covered with appropriate staff with 8 consecutive hours of RN coverage & 24 hrs of LN coverage

SW: SS=C: Failed to electronically submit accurate staffing information through PBJ

- PBJ documented facility w/o LN coverage 24 hrs/day on 5 occasions; Daily Nurse Staffing Form & Payroll Data Sheets indicated days listed covered with required LN coverage 24 hrs each day

SW: SS=C: Failed to electronically submit accurate staffing information thru PBJ

- PBJ Report for 1 quarter with excessively low staffing & 1 quarter facility failed to have LN coverage 24 hrs/day on 14 days & 1 quarter with lack of LN coverage on 10 days; Daily Nurse Staffing Form & Payroll Data Sheets indicated days listed had appropriate staff & no concerns with low weekend staffing noted; Adm stated PBJ reports submitted from outside firm

NE: SS=C: Failed to electronically submit complete & accurate staffing information to the Federal regulatory agency through PBJ when facility failed to accurately submit hourly staffing data for all weekend personnel; failed to submit complete & accurate staffing information to Federal regulatory agency through PBJ when facility failed to accurately submit hourly staffing data for all weekend personnel

- 3 quarters revealed facility failed to have sufficient staffing for weekends; review of nursing schedule & PBJ for weekends revealed facility had sufficient weekend staff coverage; Adm reported info not accurately recorded r/t how staff scheduled to work

NE: SS=C: Failed to submit complete & accurate staff information through PBJ as required

- PBJ reports excessively low weekend staffing & review of hours revealed appropriate weekend & LN coverage

NW: SS=C: Failed to submit complete & accurate staffing information thru PBJ as required placing residents at risk for inadequate staffing

- 1 quarter indicated excessively low weekend staffing; review of nursing schedule revealed adequate staffing on duty provided; staff reported if staff forgot to clock in or not on schedule, it would not show up in system

NW: SS=D: Failed to submit complete & provide accurate staffing information through the PBJ as required placing residents at risk for unidentified & ongoing inadequate nurse staffing

- PBJ indicated facility had excessively low weekend staff; Adm verified facility sent information to corporate then corporate would send collected information to "Prime View" which is a data collection program & that was final information submitted to PBJ; Adm verified facility had adequate staffing & unsure how it was incorrectly submitted

NW: SS=F: Failed to submit complete & accurate staffing information thru PBJ as required

- PBJ reports indicated no RN hours for October, November or December; quarter 2, 3 & 4, 2025 facility failed to submit data for quarter; review of LN data revealed LN on duty 24 hrs/day, 7 days/wk & RN on duty at least 8 hrs/day 7 days/wk & adequate staffing on weekends of above quarters

F868 QAA Committee

NW: SS=F: Failed to ensure Medical Director attended the QAA Committee meetings at least quarterly as required

- QAA documentation lacked evidence that medical director attended any of the meetings reviewed

F880 Infection Prevention & Control

SE: SS=E: Failed to maintain an effective infection control program r/t EBP; facility failed to ensure adequate hand hygiene & PPE when caring for residents; additionally, staff failed to store respiratory equipment in sanitary manner placing residents at risk for infections

- Observed fall mat next to bed with cracks & frayed areas exposing inner foam
- Observed catheter bag resting on floor next to bed & no PPE for EBP in or around room & no signage alerting staff to EBP
- Observed catheter bag on floor & dignity bag wadded up & no PPE in or around room & no signs instructing staff on EBP
- Observed suprapubic catheter & no EBP PPE & no signage
- Observed CNA performed incontinence care & removed fasteners from side of brief then picked up trash can & went to other side of bed then wearing same gloves removed fastener from other side & cleaned resident's buttocks then wearing same soiled gloves

placed clean brief under resident's dirty brief then wiped front peri-area & removed soiled brief then adjusted clean brief, wiped peri area then applied new gloves w/o hand hygiene then fastened brief then continued dressing resident then removed gown gloves & tied up trash then washed hands

- Observed floor mattress worn at corners
- Observed catheter bag on floor & CNA emptied bag after washing hands & donning gloves & did not don gown
- Observed CNA & CMA assisted resident & handed resident tissue, resident blew nose & handed tissue to CNA then CNA grabbed tissue with ungloved hand & threw it away then CNA continued assisting resident, then applied gown w/o performing hand hygiene & hooked up sling to Hoyer & staff attached catheter at shoulder level during Hoyer transfer then CMA placed bag on bed beside resident as continued; when finished CMA washed hands & applied glove to 1 hand only to empty catheter bag & held catheter bag with ungloved hand, opened spout & drained urine
- Observed O2 tubing on top of O2 concentrator, unbagged

SE: SS=D: Failed to maintain effective infection control program related to delivery of laundry to residents' rooms with potential to lead to cross-contamination & spread of communicable diseases to residents of facility

- Observed 2 laundry staff delivering laundry to resident rooms & staff did not perform hand before entered rooms or after exited resident rooms

SE: SS=D: Failed to implement adequate & acceptable infection control practices for 2 residents r/t urinary catheter tubing & drainage bags resting on the floor; facility failed to ensure staff implemented proper EBP PPE with cares placing resident at risk for infections

- Observed catheter dignity bag resting on floor while attached to foot of bed on multiple occasions; observed CNA performed care & re-adjusted resident in bed & CNA removed & changed resident's wet linens with gloves only

SW: SS=F: Failed to implement EBP for 1 resident who had indwelling urinary catheter & shared use of a full body lift sling placing residents residing in facility at risk of infectious disease processes

- POS for EBP r/t urinary catheter; observed 2 CNAs used full-body mechanical lift to transfer resident from w/c to toilet wearing gowns & gloves & provided toileting hygiene for resident, reattached brief then placed resident in bed & then took lift & sling out of room staff reported lift used for 2 other residents

SW: SS=D: Failed to use adequate hand hygiene when caring for residents; additionally, staff failed to disinfect mechanical lift after use

- Observed 2 staff brought mechanical lift to room & transferred resident to bed & resident incontinent of BM; during care, staff doffed gloves & applied new gloves w/o hand hygiene on multiple occasions; when finished, removed lift from room & placed in another resident room w/o sanitation completed on lift; staff reported facility w/o sanitation wipes to wipe off lift between residents

NE: SS=D: Failed to implement adequate EBP PPE for 1 resident wile accessing resident's G-tube for flushing; failed to ensure sanitary environment for laundry area placing residents at risk for infections r/t lack of proper PPE usage & possible contaminated laundry

- Observed ceiling in clean linen processing room with paint flaking & missing in multiple areas above residents' clean laundry & clean linen folding counter cluttered with items not resident clean laundry including staff purse, laptop & desk organizer with pens/pencils/scissors; observed soiled laundry washing area cluttered & backed up with resident linen & clothes in bags stacked on floor blocking staff hand washing sink, eye-wash station & washer laundry-soap refill; multiple areas of ceiling with paint chipped & missing & wall on dryer side with multiple areas of chipped & missing paint
- Observed 2 LNs accessed & flushed resident's G-tube with tap water; LNs performed proper hand hygiene before & after procedure & donned gloves but neither L wore gown as required; POS for EBP

NE: SS=D: Failed to ensure sanitary & comfortable environment to help prevent development & transmission of communicable diseases & infections when staff failed to provide EBP for 1 resident; failed to don gloves when emptying 1 resident's urinary catheter; also failed to wear gloves when picking up uncovered urinary catheter bag from floor placing residents at risk for possible exposure to infection

- Observed no EBP signage outside 1 resident's door but PPE on inside of room door; observed resident's room door opened partway & resident with uncovered catheter bag & tubing on floor in front of recliner; CNA entered room w/o donning gloves or gown & assisted resident with sitting in recliner then left room with catheter bag & tubing still on floor; observed resident's catheter bag & tubing on floor & LN entered room & with ungloved hand picked up catheter bag, placed it on walker beside recliner & left room; observed CNA entered resident's room w/o gown, applied gloves & emptied catheter bag & while emptying took graduated cylinder from BR & placed on floor w/o barrier, & after emptying into toilet, set cylinder on top of toiled

NW: SS=E: Failed to post signage for 6/7 residents regarding use of EBP to ensure staff were aware placing all residents at risk for spread of infections; facility also failed to ensure staff changed gloves properly during incontinence care for 1 resident placing resident at risk for infection

- Observation of 6/7 resident rooms where EBP protocol was to be followed; no EBP signage was found in room or on doorway
- EMR lacked documentation resident had order for Foley catheter & documentation staff monitored I&O; observed 1 CNAs transferred resident via mechanical lift; & performed catheter care; during care 1 CNA changed gloves w/o performing hand hygiene & 1 CNA failed to change gloves between soiled & clean procedure & assisted with resident donning clothing with soiled gloves on

NW: SS=E: Failed to cover clean linen & clothing when transporting through facility to prevent potential contamination, which could lead to infection

- Observed housekeeping staff took uncovered laundry cart with clean resident clothing hanging up & linens on shelf thru facility

NW: SS=F: Failed to implement a water management program for Legionella disease

- Maintenance staff unable to locate or retrieve information r/t Legionella water testing or water management r/t if or when it had been completed & testing results; Adm staff verified facility unable to find information on Legionella policy of book that maintenance staff had documented water management for Legionella

F881 Antibiotic Stewardship Program

SW: SS=D: Failed to ensure staff adhered to the principles of antibiotic stewardship through monitoring for appropriate use of antibiotics prescribed for 1 resident to prevent antibiotic resistance & spread of multidrug resistant organisms within facility

- Progress Note" on 02/05/25 at 05:02 PM documented 1 resident c/o of painful urination & upset stomach & reported felt like had a UTI; Staff obtained a urine sample & sent it to the lab; POS to administer Keflex 500 milligrams BID x 7 days; resident's " Laboratory Report " dated 02/07/25 at 08:00 AM, documented C&S report of the susceptible antibiotics to administer for the UTI; Keflex was not on list of susceptible antibiotics for infection; lab report documented it was sent to provider via modem & faxed to provider on 02/09/25; MAR documented resident was administered Keflex 500 mg, p.o., BID from 02/05/25 through 02/12/25; similar incident occurred August 2025 with Keflex again not on susceptible ABT & resident received Keflex the entirety of POS

NE: SS=F: Failed to develop & implement core elements of antibiotic stewardship to ensure an effective infection prevention & control program including antibiotic stewardship for residents of the facility

- Infection Control Log from 8-24 thru7-25 lacked evidence of tracking & ID of possible infection outbreaks at facility, lacked consistent ID of infection & of ABT administration; facility unable to provide evidence of documentation of consistent documentation of infection control surveillance

F882 Infection Preventionist Qualifications/Role

SE: SS=F: Failed to ensure designated Infection Preventionist (IP) was trained & certified in infection prevention & control placing all residents at increased risk for infectious disease

- Adm staff revealed facility did not have certified IP as previous IP left on 6-1-25 & current IP not certified

NW: SS=F: Failed to ensure the staff member designated as the Infection Preventionist, who was responsible for facility's Infection Prevention & Control Program, completed specialized training in infection prevention & control

- Adm Nurse stated responsible for IPC but lacked certification as IP; Adm stated had been unable to fill position

F883 Influenza & Pneumococcal Immunizations

NE: SS=D: Failed to offer or obtain informed declinations or a physician-documented contraindication for PCV20 & pneumococcal vaccination for 3 residents placing residents at increased risk for complications related to pneumonia

- Records lacked documentation PCV20 was offered or declined & lacked documentation of historical administration of physician-documented contraindication for 3 residents

NW: SS=E: Failed to offer, obtain informed declination, or physician documented contraindication for PCV20 per latest guidance from CDC placing residents at risk for pneumococcal infection and related complications

- Review of 5 records lacked evidence facility/representative received or signed consent to receive or informed declination for PCV20

F921 Safe/Functional/Sanitary/Comfortable Environment

SE: SS=F: Failed to provide housekeeping & maintenance services to ensure a safe & sanitary environment in facility outside kitchen access hallway & laundry area creating risk for impaired safety & cleanliness

- Observed kitchen with hallway from kitchen to outside with multiple broken tiles & standing water on floor which was being tracked thru kitchen & staff reported when it rains, water comes in entrance hallway to kitchen & must be mopped up to keep water out of kitchen
- Observed laundry with exposed sewage pipe between washer was open & not capped; unsanitizable, unsealed ceiling in dryer room r/t missing & flaking paint; unsanitizable walls in washing & drying area along with door frame & laundry storage cabinets due to being heavily scuffed with exposed wood & chipped paint; wall-mounted thermostat w/o cover with exposed electrical components

SE: SS=F: Failed to ensure a safe environment in all areas of the facility including those used by visitors & staff creating risk for impaired safety & cleanliness

- Observed clean utility closet with torn & missing wallpaper on end of storage shelf with exposed wood; fluorescent light cover with missing piece that exposed fluorescent bulbs; 2 clean utility closet with multiple holes in walls with exposed & flaking sheetrock & fluorescent light cover cracked & with broken area; clean linen storage & folding area with numerous areas with cracks & flaking paint, attic access door with missing paint & framing around access door with exposed wood, 1 fluorescent lights missing light cover; ceiling in washer/dryer room with missing paint with several holes, ceiling & ceiling fan covered in dust & tops of washers & dryers covered in dust & window AC unit dirty & covered with dust, along with attic fan vent open & dirty above washers; O2 storage closet with no cover over closet light fixture

NE: SS=F: Failed to ensure a safe & sanitary environment in all areas of facility including the laundry area placing residents at risk for contaminated laundry

- Cited findings noted in F880 r/t missing & flaking paint in laundry area & clutter in laundry area

F924 Corridors Have Firmly Secured Handrails

SE: SS=E: Failed to provide a safe & functional handrails in 1/2 hallways placing residents at risk of impaired safety

- Observed numerous handrails in 1 hallway loose & easily moved by hand; maintenance staff & Adm unaware of loose handrails

F947 Required In-Service Training for Nurse Aides

SE: SS=F: Failed to ensure mandatory 12 hours of education were completed for CNAs as required placing residents at risk for decreased quality of care

- Records revealed 1 CMA had not completed any of mandatory 12 hours of education in last 12 months

SW: SS=F: Failed to develop, implement, & permanently maintain an in-service training program for CNA staff with required topics & no less than 12 hours/yr

- 1 CNA lacked ANE, Social Media training & dementia training
- 3 CNAs' total hours not calculated for 12 hours required

SW: SS=F: Failed to develop, implement, & permanently maintain in-service training program for CNA staff with required topics & no less than 12 hours per year

- Personnel records revealed 2 CNAs lacked total hours calculated fo 12 required hours & 1 CNA lacked ANE & Social Media training & hours not calculated for 12 required hours

NE: SS=F: Failed to ensure 5/5 CNA staff reviewed had required 12 hours of in-service education placing residents at risk for decreased quality of life &/or inadequate care

- Review of in-service records revealed CNA had not completed required in-services in past 12 months for 5 staff members